TITLE 10: CALIFORNIA CODE OF REGULATIONS
CHAPTER 5.8 MANAGED RISK MEDICAL INSURANCE BOARD
HEALTHY FAMILIES PROGRAM

ARTICLE 1. DEFINITIONS

2699.6500. Definitions.

(a) "Access for Infants and Mothers (AIM) Program" means the State funded program operated pursuant to Part 6.3 (commencing with Section 12695) of Division 2 of the California Insurance Code, and that provides low-cost health care coverage for pregnant women and the newborns of subscribers who are enrolled in the AIM program prior to July 1, 2004.

(b) "Agriculture" means farming in all its branches and includes: the cultivation and tillage of the soil, the production of dairy products, the production, cultivation growing and harvesting of any agricultural or horticultural commodities, the raising of livestock, bees, forbearing animals, or poultry, any practice performed by a farmer or on a farm as an incident to or in conjunction with such farming operations, including preparation for market, delivery to storage or to market or to carriers for transportation to market.

(c) "AIM infant" means a child born to an AIM subscriber who is enrolled in the AIM program on or after July 1, 2004.

(d) "Alaska Native" means any person who is an Eskimo or Aleut or other Alaska Native enrolled by the Secretary of the Interior pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601.

(e) "American Indian" means any person who is eligible under federal law (25 U.S.C. Section 1603) to receive health services provided directly by the United States Department of Health and Human Services, Indian Health Service, or by a tribal or an urban Indian health program funded by the Indian Health Service to provide health services to eligible individuals either directly or by contract.

(f) "Anniversary date" means the day each year that corresponds to the day and month a person's coverage began in the program.

(g) ''Applicant'' means:

(1) A person age 18 or over who is a parent; a legal guardian; or a caretaker relative, foster parent, or stepparent with whom the child resides, who applies for coverage under the program on behalf of a child.

(2) A person who is applying for coverage on his or her own behalf and who is 18 years of age; or an emancipated minor; or a minor not living in the home of a parent, a legal guardian, caretaker relative, foster parent, or stepparent.

(3) A minor who is applying for coverage on behalf of his or her child.

(4) A person who is age 19 or over and who is applying for coverage on his or her own behalf and/or that of another child-linked adult.

(h) “Benefit year” means the twelve (12) month period commencing July 1 of each year at 12:01 a.m.

(i) ‘‘Board’’ means the Managed Risk Medical Insurance Board.

(j) "Caretaker relative" means a relative who provides care and supervision to a child if there is no parent living in the home. The caretaker relative may be any relation by blood, marriage, or adoption.

(k) "Child-linked adult" means:

(1) A parent living in the home with his or her child under age 19 who is enrolled in the program, or in no-cost Medi-Cal, or is eligible and applying for no-cost Medi-Cal.

(2) A stepparent living in the home with the parent described in (1).

(3) A caretaker relative living in the home with a child under age 19 who is enrolled in the program, or in no-cost Medi-Cal, or is eligible and applying for no-cost Medi-Cal. For any child or group of siblings, only one (1) caretaker relative may be eligible as a child-linked adult.

(4) A legal guardian living in the home with a child under age 19 who is enrolled in the program, or in no-cost Medi-Cal, or is eligible and applying for no-cost Medi-Cal. For any child or group of siblings, only one (1) legal guardian may be eligible as a child-linked adult.

(l) “Community provider plan” means that participating health plan in each county that has been so designated by the Board pursuant to Section 2699.6805.

(m) “Family contributions’’ means the monthly cost to an applicant for “family child contributions” and “family parent contributions.” Family contributions do not include copayments for services.

(n) “Family child contributions” means the monthly cost to an applicant to enable a subscriber child or subscriber children to participate in the program. Family child contributions do not include copayments for services.

(o) “Family parent contributions” means the monthly cost to an applicant to enable a subscriber parent or subscriber parents to participate in the program. Family parent contributions do not include copayments for services.

(p) “Family contribution sponsor” means a person or entity that is registered with the Program and that pays the family child contributions and/or family parent contributions on behalf of an applicant for any twelve (12) consecutive months of the subscriber child or subscriber parent’s participation in the program. A family contribution sponsor may sponsor a subscriber parent linked to a subscriber child enrolled in the program if the subscriber child is sponsored, or may sponsor only the subscriber parent if the subscriber parent is not linked to any subscriber children enrolled in the program and instead is linked to a child enrolled in no-cost Medi-Cal.

(q) "Family member" means the following persons living in the home, unless the individual receives public assistance benefits such as SSI/SSP:

(1) Children under age 21 of married or unmarried parents living in the home.

(2) The married or unmarried parents of the child or sibling children.

(3) The stepparents of the child or sibling children.

(4) An unborn child of any family member.

(5) Children under age 21 who are away at school and who are claimed as tax dependents.

(r) “Family value package” means the combination of participating health, dental, and vision plans available to subscribers in each county offering the lowest price and each of the combinations offering a price within seven and one half percent (7.5%) of the average price of the lowest priced combination and the second lowest price combination of health, dental, and vision plans. The second lowest price combination is calculated by summing the second lowest price health plan, the second lowest price dental plan, and the second lowest price vision plan. If only one health, dental, or vision plan is available to subscribers in a county, the price of the one available plan shall be used in the calculations of the second lowest price combination. A health, dental, or vision plan with a service

area which does not include zip codes in which at least eighty-five percent (85%) of the residents of the county reside or that has enrollment limits unrelated to network capacity shall not be considered the lowest or second lowest price plan, unless it is the only health, dental, or vision plan in the county. In addition, any combination of health, dental, and vision plans in which the health, dental, and vision plan are each available in at least one plan combination that is within seven and one half percent (7.5%) of the average price of the lowest and second lowest price combination of health, dental, and vision plans, is a family value package. In all family value package calculations, the health plan rate to be used is the rate for subscriber children from one year old up to the age of nineteen. The dental and vision plan rates to be used are the rates for subscriber children. The family value package determinations shall be made once each year by the Board, no later than the last day of March for the following benefit year, based on calculations using the prices of the plans that at the time of the calculations are expected to be available the following benefit year. Calculations will not be redone if plans are later dropped from or added to a county. However, if the Board at any time determines that the seven and one half percent (7.5%) level is insufficient to assure that adequate network capacity exists in a specified county so that all subscribers may be enrolled in a family value package, the Board may increase the percentage for that county to a percentage at which sufficient capacity is assured. Such increased percentage shall be in effect only for the benefit year in which the increase is made. The Board may determine, if requested as a part of a rural demonstration project for a special population, that a combination of health, dental, and vision plans in a county with a price higher than the family value package may still be deemed a family value package for applicants and subscribers that are members of the special population; in addition the Board may determine, if requested as part of a rural demonstration project for rural area residents, that a combination of health, dental, and vision plans in a county with a price higher than the family value package may still be deemed a family value package for subscribers that are residents of the rural area. The Board may determine that a combination of health, dental, and vision plans in a county that includes health and vision plans available in at least one family value package plan combination is deemed a family value package even if the dental plan is not in any other family value package plan combination, but only for applicants with subscribers who are enrolled prior to the beginning of the benefit year in that dental plan, and only if the Board determines it necessary in order to avoid requiring fifty percent (50%) of subscribers or one-thousand (1,000) subscribers in a county to change their dental plan.

(s) “Federal Poverty Level” means the level determined by the “Poverty Guidelines for the 48 Contiguous States and the District of Columbia” as contained in the Annual Update of HHS Poverty Guidelines as published

in the Federal Register by the U.S. Department of Health and Human Services.

(t) "Household income" means the total annual income of all family members in a household. Income includes before tax earnings from a job, including cash, wages, salary, commissions and tips, selfemployment net profits, Social Security, State Disability Insurance (SDI), Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability workers' compensation, unemployment benefits, child support, alimony, spousal support, pensions and retirement benefits, loans to meet personal needs, grants that cover living expenses, settlement benefits, rental income, gifts, lottery/bingo winnings and interest income. Income excludes public assistance program benefits such as SSI/SSP and CalWORKS payments, foster care payments, general relief, loans, grants or scholarships applied toward college expenses, or earned income of a child aged 13 or under, or a child attending school. Income does not include income exclusions applicable to all federal means tested programs such as, disaster relief payments, per capita payments to Native Americans from proceeds held in trust and/or arising from use of restricted lands, Agent Orange payments, Title IV student assistance, energy assistance payments to low income families, relocation assistance payments, victims of crime assistance program, Spina Bifida payments, earned income tax credit and Japanese reparation payments.

(u) "Income deduction" means any of the following:

(1) Work expenses of $90 per month for each family member working or receiving disability worker's compensation or State Disability Insurance. If a family member earns less than $90, the deduction can only be for the amount earned.

(2) Child care expenses while a family member works or trains for a job of up to $200 per month for each family member under age 2, up to $175 per month for each family member over age 2 and dependent care expenses of up to $175 for a disabled dependent.

(3) The amount paid by a family member per month for any court ordered alimony or child support.

(4) A maximum of $50 for child support payments or alimony received. If less than $50 in child support and/or alimony is received, the deduction can only be for the amount received.

(v) "Indian Health Service Facility" means a tribal or urban Indian organization operating health care programs or facilities with funds from the United States Department of Health and Human Service's Indian Health Service,

pursuant to the Indian Health Care Improvement Act (25 U.S.C. Section 1601) or the Snyder Act (25 U.S.C. Section 13).

(w) "Living in the home" means all of the following:

(1) Physically present in the home;

(2) Temporarily absent from the home because of hospitalization, visiting, vacation, work-related trips, or other similar reasons. A temporary absence is normally one where a person leaves and returns to the home in the same or the following month.

(3) Away at school or vocational training if the person will resume living in the home as evidenced by the person's return to the home for vacations, weekends, and other times.

(4) When a child stays alternately with each of his or her parents and the child's parents are separated or divorced, the home in which the child is living shall be determined as follows:

(A) The child is determined to be living in the home of the parent with whom the child stays for the majority of the time.

(B) If the child spends an equal amount of time with each parent, the child is determined to be living in the home of the parent who has the majority of the responsibility for the care of the child. Factors that determine majority responsibility include but are not limited to which parent decides where the child attends school, deals with the school on educational decisions and problems, controls participation in extracurricular and recreational activities, arranges medical and dental care services, claims the child as a tax dependent, and purchases and maintains the child's clothing.

(C) If both parents exercise an equal share of responsibility for the child and the child spends an equal amount of time with each parent, the child is determined to be living in the home of the parent who meets one of the following conditions in the order specified:

1. Is designated, through mutual agreement of both parents, as the primary parent for purposes of the program or Medi-Cal.

2. Is otherwise eligible for the program.

3. If both parents are eligible for the program then the child is determined to be living in the home of the parent who first applied for the program or Medi-Cal on behalf of the child.

(x) “Migratory worker” means an individual whose principal employment is in agriculture, fishing, and/or forestry, on a seasonal basis, as opposed to year-round employment; and who, for purposes of employment, does establish a temporary place of residence. Migrant workers live in a work area temporarily. Such employment must have been within the last twenty-four months.

(y) “Parent” means the natural or adoptive parent of a child.

(z) “Parental coverage start date” means the effective date for which the State of California enacts appropriation for the coverage of child linked adults pursuant to a budget act and/or any other applicable state statute.

(aa) ‘‘Participating dental plan’’ means any of the following plans that is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal dental services under insurance policies or contracts, or membership contracts, in consideration of premiums or other periodic charges payable to it, and that contracts with the Board to provide coverage to program subscribers:

(1) A dental insurer holding a valid outstanding certificate of authority from the Insurance Commissioner.

(2) A specialized health care service plan as defined under subdivision (o) of Section 1345 of the Health and Safety Code.

(bb) ‘‘Participating health plan’’ means any of the following plans that is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal health care services under insurance policies or contracts, medical and hospital service arrangements, or membership contracts, in consideration of premiums or other periodic charges payable to it, and that contracts with the Board to provide coverage to program subscribers:

(1) A private health insurer holding a valid outstanding certificate of authority from the Insurance Commissioner.

(2) A health care service plan as defined under subdivision (f) of Section 1345 of the Health and Safety Code. The term health care service plan shall include a plan operating as a geographic managed care plan as defined in Insurance Code Section

12693.16, in the area which it operates pursuant to a contract entered into under Article 2.91 (commencing with Section 14089 of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

(3) A county organized health system as defined in Insurance Code Section 12693.05, in the county in which it provides comprehensive health care to eligible Medi-Cal beneficiaries.

(4) A local initiative as defined in Insurance Code Section 12693.08, in the region in which it provides comprehensive health care to eligible Medi-Cal beneficiaries.

(cc) "Participating plan" means a participating health, participating dental or participating vision care plan.

(dd) ''Participating vision care plan'' means any of the following plans that is lawfully engaged in providing, arranging, paying for, or reimbursing the cost of personal vision services under insurance policies or contracts, or membership contracts, in consideration of premiums or other periodic charges payable to it, and that contract with the Board to provide coverage to program subscribers:

(1) A vision insurer holding a valid outstanding certificate of authority from the Insurance Commissioner.

(2) A specialized health care service plan as defined under subdivision (o) of Section 1345 of the Health and Safety Code.

(ee) ''Program'' means the Healthy Families Program.

(ff) (1) "Qualified alien" means an alien who, at the time he or she applies for, receives, or attempts to receive program benefits, is, under Section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) (8 U.S.C. Section 1641), any of the following:

(A) An alien lawfully admitted for permanent residence under the Immigration and Naturalization Act (INA) (8 U.S.C. Section 1101 et seq.).

(B) An alien who is granted asylum under Section 208 of the INA (8 U.S.C. Section 1158).

(C) A refugee who is admitted to the United States under Section 207 of the INA (8 U.S.C. Section 1157).

(D) An alien who is paroled into the United States under Section 212(d)(5) of the INA (8 U.S.C. Section 1182 (d)(5)) for a period of at least one year.

(E) An alien whose deportation is being withheld under Section 243(h) of the INA (8 U.S.C. Section 1253(h), as in effect immediately before the effective date (April 1, 1997) of Section 307 of Division C of Public Law 104-208, or Section 241(b)(3) of such Act (8 U.S.C. Section 1251(b)(3)) (as amended by Section 305(a) of Division C of Public Law 104-208).

(F) An alien who is granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to April 1, 1980 (8 U.S.C. Section 1153(a)(7)). (See editorial note under 8 U.S.C. Section 1101, "Effective Date of 1980 Amendment.")

(G) An alien who is a Cuban and Haitian entrant (as defined in Section 501(e) of the Refugee Education Assistance Act of 1980) (8 U.S.C. Section 1522nt.).

(H) An alien who, under Section 431(c)(1) of PRWORA (8 U.S.C. Section 1641 (c)(1)), meets all of the conditions of subparagraphs 1., 2., 3., and 4. below:

1. The alien has been battered or subjected to extreme cruelty in the United States by a spouse or a parent, or by a member of the spouse's or parent's family residing in the same household as the alien, and the spouse or parent of the alien consented to, or acquiesced in, such battery or cruelty.

2. There is a substantial connection between such battery or cruelty and the need for the benefits to be provided.

3. The alien has been approved or has a petition pending which sets forth a prima facie case for any of the following:

    a. Status as a spouse or child of a United States citizen pursuant to clause (ii), (iii), or (iv) of Section 204(a)(1)(A) of the INA (8 U.S.C. Section 1154(a)(1)(A)(ii), (iii) or (iv)).

b. Classification pursuant to clause (ii) or (iii) of Section 204(a)(1)(B) of the INA (8 U.S.C. Section 1154 (a)(1)(B)(ii) or (iii)).

c. Cancellation of removal under Section 240A of the INA (8 U.S.C. Section 1229b) (as in effect prior to April 1, 1997).

d. Status as a spouse or child of a United States citizen pursuant to clause (i) of Section 204(a)(1)(A) of the INA (8 U.S.C. Section 1154(a)(1)(A)(i)) or classification pursuant to clause (i) of Section 204(a)(1)(B) of the INA (8 U.S.C. Section 1154(a)(1)(B)(i)).

e. Cancellation of removal pursuant to Section 240A(b)(2) of the INA (8 U.S.C. Section 1229b(b)(2)).

4. For the period for which benefits are sought, the individual responsible for the battery or cruelty does not reside in the same household or family eligibility unit as the individual subjected to the battery or cruelty.

(I) An alien who, under Section 431(c)(2) of the PRWORA (8 U.S.C. Section 1641 (c)(2)), meets all of the conditions of subparagraphs 1., 2., 3., 4. and 5. below:

1. The alien has a child who has been battered or subjected to extreme cruelty in the United States by a spouse or a parent of the alien (without the active participation of the alien in the battery or cruelty), or by a member of the spouse's or parent's family residing in the same household as the alien, and the spouse or parent consented or acquiesced to such battery or cruelty.

2. The alien did not actively participate in such battery or cruelty.

3. There is a substantial connection between such battery or cruelty and the need for the benefits to be provided.

4. The alien meets the requirements of subparagraph (H)(3) above.

5. For the period for which benefits are sought, the individual responsible for the battery or cruelty does not reside in the same household or family eligibility unit as the individual subjected to the battery or cruelty.

(J) An alien child who meets all of the conditions of subparagraphs 1., 2., 3., and 4. below:

1. The alien child resides in the same household as a parent who has been battered or subjected to extreme cruelty in the United States by that parent's spouse or by a member of the spouse's family residing in the same household as the parent and the spouse consented or acquiesced to such battery or cruelty.

2. There is a substantial connection between such battery or cruelty and the need for the benefits to be provided.

3. The alien child meets the requirements of subparagraph (H)(3) above.

4. For the period for which benefits are sought, the individual responsible for the battery or cruelty does not reside in the same household or family eligibility unit as the individual subjected to the battery or cruelty.

(2) For purposes of subparagraphs (1)(H), (1)(I), and (1)(J), there is a "substantial connection between such battery or cruelty and the need for benefits to be provided" if the alien declares, and the program verifies, any of the following circumstances:

(A) The alien or the alien's child is receiving cash assistance based on the battery or extreme cruelty.

(B) The benefits are needed due to a loss of financial support resulting from the alien's and/or his or her child's separation from the abuser.

(C) The benefits are needed because the alien or his or her child requires medical attention or mental health counseling, or has become disabled, as a result of the battery or cruelty.

(D) The benefits are needed to provide medical care during a pregnancy resulting from the abuser's sexual assault or abuse of, or relationship with, the alien or his or her child, and/or to care for any resulting children.

(E) The medical coverage and/or health care services are needed to replace medical coverage or health care services the applicant or child had when living with the abuser.

(3) An alien who is a qualified alien pursuant to subparagraphs (1)(H), (1)(I), or (1)(J), will remain eligible for the program as long as the need for benefits related to the battery or cruelty is necessary as determined by the program, and the alien continues to meet all other program eligibility requirements. The program shall review the alien's circumstances to evaluate the subscriber's continued need for program benefits at the annual eligibility review.

(gg) "Qualifying event" means one of the following situations in which a child-linked adult may enroll in the program:

(1) A subscriber child through whom the child-linked adult is eligible enrolls in no-cost Medi-Cal or the program and the child-linked adult requests enrollment at the same time as the child. If the child-linked adult is not the applicant on behalf of the subscriber child, the child-linked adult may request enrollment within 2 months of the subscriber child's enrollment in no-cost Medi-Cal or the program.

(2) A subscriber child through whom the child-linked adult is eligible qualifies for an additional year of coverage under no-cost Medi-Cal or the program pursuant to Section 2699.6625 and the child-linked adult requests enrollment at the time of the child's annual eligibility review. If the child-linked adult is not the applicant on behalf of the subscriber child, the child-linked adult may request enrollment within 2 months of the subscriber child's qualification for an additional year of coverage through no-cost Medi-Cal or the program.

(3) A child-linked adult loses no-cost Medi-Cal coverage and requests enrollment within 2 months after notification of this loss of coverage.

(4) A subscriber child turns 19 and qualifies to participate in the

program as a subscriber parent, and requests enrollment within 2 months of his or her 19th birthday.

(5) A child-linked adult has lost or will lose coverage under employer sponsored coverage as a result of one of the following and the child-linked adult requests enrollment within 2 months of the termination of coverage.

(A) The child-linked adult or other individual through whom the child-linked adult was covered lost employment or experienced a change in employment status.

(B) The child-linked adult or other individual through whom the child-linked adult was covered changed address to a zip code that is not covered by the employer-sponsored coverage.

(C) The employer of the child-linked adult or other individual through whom the child-linked adult was covered discontinued health benefits to all employees or dependents, or ceased to provide coverage or contributions for one or more categories of employees or dependents.

(D) Death of the individual, through whom the child-linked adult was covered, or a legal separation or divorce from the individual through whom the child-linked adult was covered.

(E) The child-linked adult was covered under a COBRA policy, and the COBRA coverage period has ended.

(6) A subscriber parent's period of disqualification pursuant to Subsection 2699.6611(d) has expired and enrollment is requested within 2 months of the end of the period of disqualification.

(7) The household income for a child-linked adult falls to a level at or below 200% of the federal poverty level and the child-linked adult requests enrollment within 2 months of this change in income.

(8) A subscriber parent marries and his or her spouse requests enrollment within 2 months of newly obtaining the status of a child-linked adult.

(9) A subscriber child begins living in the home with a parent, caretaker relative, or legal guardian and the parent, caretaker relative, or legal guardian requests enrollment within 2 months of newly obtaining the status of a child-linked adult.

(10) The program informs a child-linked adult who previously applied at a time when the program was closed to new enrollment that he or she may apply and he or she requests enrollment within 2 months of notification of the program's opening to new enrollment for child-linked adults.

(hh) “Rural demonstration projects” means health, dental and vision plan projects approved by the Board to address the unique access needs of special populations and/or residents of rural medical service study areas.

(ii) “Rural Medical Service Study Area” means an area with (1) a population density of less than 250 persons per square mile: and (2) no town with a population in excess of 50,000 within the area, as determined by the Office of Statewide Health Planning and Development.

(jj) “Seasonal worker” means an individual whose principal employment is in agriculture, fishing and/or forestry, on a seasonal basis, as opposed to year-round employment; and who, for purposes of employment, does not establish a temporary place of residence. Seasonal workers commute to work in the area of their permanent address. Such employment must have been within the last twenty-four months.

(kk) “Special population” means seasonal workers, migratory workers or American Indians.

(ll) “State Supported Services” means abortions that are not the result of incest or rape, and are not necessary to save the life of the mother.

(mm) "Stepparent" means a person who is married to the parent of a child and who is not the other parent of the child.

(nn) "Subscriber" means either a “subscriber child” or a “subscriber parent.”

(oo) “Subscriber child” means a person age 18 or a child who is eligible for and participates in the program.

(pp) “Subscriber parent” means a child-linked adult age 19 or over who is eligible for and participates in the program.

(qq) Tenses, and Number. The present tense includes the past and future, and the future the present; the singular includes the plural and the plural the singular.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code.

Reference: Sections 12693.02, 12693.03, 12693.045, 12693.06, 12693.065, 12693.08, 12693.09, 12693.10, 12693.70, 12693.105, 12693.11, 12693.12, 12693.13, 12693.14, 12693.16, 12693.17, 12693.755 and 12693.91, Insurance Code.

ARTICLE 2. ELIGIBILITY, APPLICATION, AND ENROLLMENT

2699.6600. Application.

(a) To apply for the program:

(1) An applicant shall submit all information, documentation, and declarations required in subsection (c) of this section and a personal check, cashier's check or money order for the first month's required family contribution for the program, or a personal check, cashier's check or money order for the first three months' required family contribution if the applicant wishes to receive the fourth month of coverage with no required family contribution.

(2) No payment from the applicant pursuant to (1) is required if the applicant has a family contribution sponsor and both the sponsor's family contribution payment for twelve (12) months and the family contribution sponsorship payment form accompany the application.

(3) No payment from the applicant pursuant to (1) is required if the applicant or the person for whom application is being made is American Indian or Alaska Native and submits acceptable documentation as described in Subsection (c)(1)(GG).

(4) Payment in full of the following arrears, incurred within the prior twelve (12) months, by the applicant is required prior to enrollment of a person under age 19:

(A) Family child contributions owed on behalf of any person under age 19 for whom the same applicant previously applied;

(B) Family child contributions owed on behalf of a person under age 19 for whom the applicant did not previously apply but for whom the applicant is currently requesting coverage if the applicant:

1. Is the parent of the person under age 19 for whom premiums are owed; and

2. Lived in the same home as the person under age 19 when the premiums were incurred.

(5) Payment in full of the following arrears, incurred within the prior twelve (12) months, by the applicant is required prior to enrollment of a person age 19 or over:

(A) Family contributions owed on behalf of any person for whom the same applicant previously applied;

(B) Family child contributions owed on behalf of a person under age 19 for whom the applicant did not previously apply but for whom the applicant is currently requesting coverage if the applicant:

1. Is the parent of the person under age 19 for whom premiums are owed; and

2. Lived in the same home as the person under age 19 when the premiums were incurred.

(C) Family parent contributions owed on behalf of a person for whom the applicant is requesting coverage for coverage provided on or after the person's 19th birthday.

(6) The program application, entitled "Family Health Coverage Mail-In Application, for Medi-Cal and Healthy Families" (MC321 HFP, Rev 4/05), is hereby incorporated by reference. Alternatively, the program shall utilize the school lunch application and any supplemental forms received pursuant to Section 14005.41 of the Welfare and Institutions Code to make an eligibility determination.

(b) The applicant shall sign and date the following declaration: I declare under penalty of perjury under the laws of the State of California that the answers I have given in this Application and the documents given are correct and true to the best of my knowledge and belief. I declare that I have read and understand the Application Instructions, the declarations, and all information printed on this Application.

(c) (1) The application shall contain the following:

(A) The applicant's full name.

(B) The applicant's date of birth.

(C) The applicant's primary written and oral language.

(D) The home and mailing address for the applicant and for all persons for whom application is being made, the applicant's county of residence and phone number(s), and the applicant's e-mail address (optional).

(E) An indication of whether the applicant is over the age of 18 years and applying on behalf of a child or children, and/or on behalf of a child-linked adult. An indication of whether the applicant is an 18 year old applying on his or her own behalf; the applicant is an emancipated minor applying on his or her own behalf; the applicant is a minor who is not living in the home of a parent, legal guardian, caretaker relative, foster parent, or stepparent and is applying on his or her own behalf; or the applicant is a minor who is applying on behalf of his or her child.

(F) For each person for whom the applicant is applying, the following information is requested:

1. name (first, middle and last) including full birth name if different (not required for a child not yet born)

2. marital status and spouse's name

3. birth date (not required for a child not yet born)

4. birth place (not required for a child not yet born)

5. mother's first and last name and whether living in the child's household (optional for a person age 19 or over)

6. father's first and last name if living in the child's household (optional for a person age 19 or over)

7. an indication of whether the mother and father are deceased or disabled (optional for a person age 19 or over)

8. gender (not required for a child not yet born)

9. Social Security Number (optional)

10. ethnicity (optional unless the person is an American Indian),

11. relationship to applicant.

12. if the person lives away from home (optional for a person age 19 or over)

13. if the person is going to school

14. if the person has a physical, mental or emotional disability

15. if any person in the home is pregnant and if so, the expected due date

(G) A declaration that the applicant is applying to enroll in the program all of the applicant's eligible children who are not already enrolled in the program, unless the applicant is applying only on his or her own behalf.

(H) An identification of individuals living together in the home and their relationships. If an individual is pregnant, it should be indicated, along with the expected due date.

(I) A list of family members identified in (F) and (H) above, who live in the home and who had income in the previous or current calendar year.

1. If the applicant is a parent or stepparent, an 18 year old applying on their own behalf, a child-linked adult applying on his or her own behalf or that of another child-linked adult or a minor applying on his or her own behalf or on behalf of his or her child, for the household of each person applied for, the first, middle initial, last name, gender and date of birth of all family members living in the household, each person's relationship to the person applied for and their monthly income.

2. If the applicant is applying as a foster parent, caretaker relative, or legal guardian applying only on behalf of an 18 year old or a child, a statement of the monthly income of each person applied for whom they are a foster parent, caretaker relative, or legal guardian.

3. If the person for whom application is being made is a qualified alien with an affidavit of support pursuant to section 213A of the Immigration and Naturalization Act, the calculation of household income must include the sponsor's income as set forth in Section 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), unless the

person is eligible pursuant to Insurance Code Section 12693.76.

(J) Beginning one year after the parental coverage start date, for each child-linked adult for whom application is being made, an indication of his or her qualifying event as defined in Section 2699.6500.

(K) Documentation of the total monthly gross household income for either the previous or current calendar year. For each person listed pursuant to subsections (F) and (H) above, provide social security number (optional) and documentation for each source of income. Such documentation shall be provided for the previous or current year as indicated below:

1. For the previous calendar year:

   a. Federal tax return. If self-employed, a schedule C must be included. If a person with reported income on the federal tax return is a step-parent, the step-parent's W-2 form is required to determine the amount of income associated with the financially responsible parent of the child being applied for.

   b. All of the following that are applicable and that reflect the current benefit amount: copies of award letters, checks, bank statements, passbooks, or internal revenue service (IRS) 1099 forms showing the amount of Social Security, State Disability Insurance (SDI), Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability workers' compensation, unemployment benefits, child support, alimony spousal support, pensions and retirement benefits, loans to meet personal needs, grants that cover living expenses, settlement benefits, rental income, gifts, lottery/bingo winnings, dividends, or interest income.

2. For the current calendar year:

   a. Paystub or unemployment stub showing gross income for a period ending within 45 days of the date the program receives the document.

b. A letter from the person's current employer. The letter shall be dated and written on the employer's letterhead, and shall include the following:

i. The employee's name.

ii. The employer's business name, business address, and phone number.

iii. A statement of the person's current gross monthly income for a period ending within 45 days of the date the program receives the document.

iv. A statement that the information presented is true and correct to the best of the signer's knowledge.

v. A signature by someone authorized to sign such letters by the employer. The signer shall include his or her position name or job title and shall not be the person whose income is being disclosed.

c. If self employed, a profit and loss statement for the most recent three (3) month period prior to the date the program receives the document. A profit and loss statement must include the following:

i. Date.

ii. Name, address, and telephone number of the business.

iii. Gross income, gross expenses, and net profit itemized on a monthly basis.

iv. A statement on the profit and loss, signed by the person who earned the income, which states, "the information provided is true and correct."

d. A letter or Notice of Action from the County Welfare

Office issued within the last two (2) months that includes:

i. For each person for whom application is being made, a statement that the person is eligible for share-of-cost Medi-Cal,

ii. A determination of total monthly household income and monthly household income after income deductions as defined in Section 2699.6500, and

iii. A determination of the number of family members living in the household.

e. All of the following that are applicable and that reflect the current benefit amount: copies of award letters, checks, bank statements, or passbooks showing the amount of Social Security, State Disability Insurance (SDI), Retirement Survivor Disability Insurance (RSDI), veterans benefits, Railroad Retirement, disability workers' compensation, unemployment benefits, child support, alimony, spousal support, pensions and retirement benefits, loans to meet personal needs, grants that cover living expenses, settlement benefits, rental income, gifts, lottery/bingo winnings, dividends, or interest income for the previous month.

3. If documentation pursuant to 1. or 2. cannot be provided, an affidavit of income written by hand by the recipient of the income. If the individual who receives the income is unable to write the affidavit by hand because of physical or literacy limitations, the individual will sign an affidavit written on his or her behalf with a mark (unless physically incapable) and include the printed name and signature of a witness. The affidavit of income shall include the following:

a. A statement of the amount and frequency of the income received,

b. A declaration that the individual cannot provide other documentation of his or her income at the time of application to the program and that the information provided is true and correct to the

best of the individual's knowledge and belief,

c. An acknowledgment that the individual understands that the information contained in his or her affidavit may be subject to a verification by the State, and

d. The signature of the individual providing the affidavit of income and the date of signature.

(L) The name of each family member living in the home who pays court ordered child support, court ordered alimony, or health insurance and the monthly amount paid. The name and age of each person for whom payments are made for child care and/or disabled dependent care by a family member living in the home and the monthly amount paid. Documentation of court ordered child support and/or alimony paid, health insurance paid, and child care and/or disabled dependent care expenses paid. Documentation includes copies of court orders, cancelled checks, receipts, statements from the District Attorney's Family Support Division or other equivalent document.

(M) A declaration that each person for whom application is being made is not eligible for Part A and Part B of Medicare.

(N) A declaration that each person for whom application is being made is a resident of the State of California pursuant to Section 244 of the Government Code; or is physically present in California and entered the state with a job commitment or to seek employment.

(O) A declaration that the applicant will notify the program within 30 days of any change of home or mailing address of any person applied for who is accepted into the program and any change in the applicant's home or mailing address.

(P) A declaration that the applicant and each person for whom application is being made will abide by the rules of participation of the program.

(Q) A declaration that the applicant and each person for whom application is being made will abide by the rules and adhere to the policies and procedures, including dispute resolution processes, of any participating plan in which such persons

are enrolled.

(R) For each person for whom application is being made, indicate current employer sponsored health coverage or employer sponsored health coverage that was terminated in the last three months, including the reason for and date of the termination.

(S) For each person for whom application is being made, the applicant's declaration that the person is:

1. a citizen or national of the United States, or

2. a qualified alien who entered the United States prior to August 22, 1996 or who entered on or after August 22, 1996 and meets one of the criteria listed in Subsection 2699.6607 (e)(2)(B), or

3. a qualified alien who does not meet the criteria specified in subsection (S)2. above.

(T) For each declaration made pursuant to (S), documentation of the individual's status. If documentation is unavailable at the time of application, persons declaring a status listed under subsection (S) above may submit documentation within two months from the date of enrollment. If any person for whom application is being made was previously disenrolled pursuant to Section 2699.6611(a)(3), documentation for that person shall be submitted with the application.

(U) A declaration that each person for whom application is being made is not eligible for any California Public Employees Retirement System Health Benefits Program(s) or is eligible for a California Public Employees Retirement Health Benefits Program but the employer contribution for dependent(s) is less than $10.

(V) A declaration that each person for whom application is being made is not an inmate in a public correctional institution, or a patient in an institution for mental illness.

(W) A declaration that the applicant gives permission for the program to verify family income, health coverage, immigration status of each person for whom application is being made, California residence and other facts stated in the application.

(X) For each person for whom application is being made, an indication of whether the person has other health, dental or vision insurance.

(Y) An indication of whether anyone has filed a lawsuit because of an accident or injury on behalf of any person for whom application is being made.

(Z) An indication of whether the applicant wants to apply for Medi-Cal coverage for any unpaid medical expenses in the last three months prior to application for any person for whom application is being made.

(AA) The applicant shall provide all of the following:

1. A declaration that the applicant has reviewed the benefits offered by the participating health, dental and vision plans.

2. The applicant's choice of participating health, dental, and vision plans.

3. A declaration that the applicant agrees to pay the required family contribution for a period of six months, unless the applicant has a family contribution sponsor.

(BB) The applicant may provide the following optional information:

1. The applicant's choice of primary care provider/clinic and provider/clinic code, and dentist/clinic and dentist/clinic code for the person(s) for whom application is being made.

2. An indication of whether there is more than one car in the children's household.

3. An indication of whether there is more than $3,150 cash in bank accounts in the children's household.

4. An indication if the applicant does not want the application reviewed for eligibility for Medi-Cal or the Program.

(CC) If assistance in completing the application was provided by an eligible individual, a statement by the applicant that such assistance was provided.

(DD) If applicable, a declaration that the applicant is a migratory worker or seasonal worker as defined in Section 2699.6500.

(EE) If applicable, the applicant's signed authorization that the program may release information over the telephone about the application status of the individual(s) applied for by the applicant to a representative of the enrollment entity designated by the applicant on the application. This permission will end on the date the program mails the results of the eligibility determination on this application.

(FF) If the applicant received assistance from a certified application assistant, the applicant's signed authorization (if applicable) that the program may release information notifying the entity with whom the certified application assistant is affiliated of the applicant's Annual Eligibility Review date.

(GG) If an applicant or the person for whom application is being made is American Indian or Alaska Native, acceptable documentation must be submitted to exempt the applicant from family contribution payments and benefit copayments. The exemption from family contributions and benefit copayments shall occur after receipt of such documentation. Notwithstanding the previous sentence, the exemption from family contributions will begin on the date of enrollment and continue for two months pending the receipt of acceptable documentation. If acceptable documentation is not received at the end of the two month exemption period, the appropriate family contribution will be assessed pursuant to Subsection 2699.6813(a). The applicant must indicate on the application that he or she is requesting a waiver of the family contributions. Acceptable documentation for the applicant or the child includes:

1. An American Indian or Alaska Native enrollment document from a federally recognized tribe, or

2. A Certificate Degree of Indian Blood (CDIB) from the Bureau of Indian Affairs, or

3. A letter of Indian heritage from an Indian Health

Service supported facility operating in the State of California.

(HH) An indication of how the applicant learned about Medi-Cal and the program.

(II) An indication whether the applicant would like information sent to them regarding the Child Health and Disability Prevention Program (CHDP) for children and youth or the Women, Infants and Children (WIC) program.

(2) The Social Security numbers and other personal information are needed for identification and administrative purposes.

(d) For children referred pursuant to Section 14005.41 of the Welfare and Institutions Code, the program shall use the following to make an eligibility determination:

(1) For each child for whom the applicant is applying, the child's school lunch application forwarded pursuant to Section 49557.2 of the Education Code and Section 14005.41 of the Welfare and Institutions Code; and

(2) Supplemental Form for Express Enrollment Applicants (MC 368 (06/05)); and

(3) A letter or Notice of Action from the County Welfare Office issued within the last two (2) months that includes:

(A) For each person for whom application is being made, a statement that the person is eligible for share-of-cost Medi-Cal; and

(B) A determination of total monthly household income and monthly household income after income deductions as defined in Section 2699.6500; and

(C) A determination of the number of family members living in the household; and

(4) Any additional information requested by the program pursuant to Subsection 2699.6600(c)(1)(C), (F)15., (G), (M)–(Q), (U)-(W), (AA), (BB)1., (DD), (GG).

NOTE: Authority cited: Sections 12693.21, 12693.75 and 12693.755, Insurance Code. Section 14005.41, Welfare and Institutions Code.

Reference: Sections 12693.02, 12693.21, 12693.43, 12693.46, 12693.70, 12693.71, 12693.73, 12693.74, 12693.75 and 12693.755, Insurance Code.

2699.6603. Early Applications.

An applicant may apply to the program in advance for persons who are not eligible at the time of application, but who the applicant believes will become eligible within three (3) months because of one of the following:

(a) They are currently enrolled in the Medi-Cal 200% Program and will become one year old.

(b) They are currently enrolled in the Medi-Cal 133% Program and will become age 6.

(c) They are currently on Medi-Cal for at least one month of continued eligibility under no cost, full scope Medi-Cal and have been notified by the county welfare office that coverage is ending.

(d) It is anticipated that the child will be born. When the child is born, an applicant must submit documentation of the child's birth to the program, and must include the child's name, place and date of birth, and gender. The documentation and information must be received by the program within thirty (30) days from the birth for a child to be eligible pursuant to this section. Acceptable forms of documentation include a certificate of birth provided by a hospital or other health care facility, a signed statement by the health practitioner who presided over the delivery, or an equivalent document.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21, 12693.70, Insurance Code.

2699.6605. Initial Review of Application.

(a) Upon receipt of an application or an Add a Person Application form, the program shall determine if there is funding available for additional enrollment of child-linked adults in the program.

(b) (1) If there is no funding available for coverage of child-linked adults and the Board estimates that the program will be closed to new enrollment of child-linked adults for less than six (6) consecutive weeks, applications will be reviewed for completeness as set forth in Section 2699.6606 below and if complete, for eligibility. For persons age 19 and over who are determined to be eligible, the program will retain the applicant's family parent contributions

payment to use to enroll the eligible child-linked adult(s) in the program once a vacancy opens in the program. The applicant may request a refund of the family parent contributions payment but the child-linked adult for whom enrollment was requested will be removed from the program waiting list. Persons age 19 and over for whom application is being made who are determined to be eligible will be placed on a waiting list in the following categories:

(A) Child-linked adults with an annual household income after income deductions of up to and including 100 percent of the federal poverty level.

(B) Child-linked adults with an annual household income after income deductions greater than 100 percent and up to and including 150 percent of the federal poverty level.

(C) Child-linked adults with an annual household income after income deductions greater than 150 percent and up to and including 200 percent of the federal poverty level.

(2) The waiting list will be maintained as follows:

(A) Child-linked adults in category (b)(1)(B) will be placed ahead of child-linked adults in category (b)(1)(C) on the waiting list. Child-linked adults in category (b)(1)(A) will be placed ahead of child-linked adults in category (b)(1)(B) on the waiting list.

(B) Within each category, persons for whom application is being made who are determined to be eligible will be listed in the order in which completed applications were received by the program.

(C) Each applicant shall be notified of placement on the waiting list. When a vacancy occurs or funds become available, whichever is applicable, persons for whom application is being made shall be enrolled in the order in which they appear on the waiting list.

(c) If there is no funding available and the Board estimates that the program will be closed to new enrollment for six (6) consecutive weeks or more for child-linked adults, the program will so notify applicants on behalf of child-linked adults. The program will apply the family parent contributions to the family child contributions for that household unless the applicant request a refund of the family parent contributions. The program shall refund the applicant’s family parent contributions if there is no subscriber child in the household. When funds become available, the program will notify these

applicants that the program is opening for new enrollment. To request coverage when the program opens for new enrollment, an applicant who previously applied for enrollment for a childlinked adult when the program was closed to new enrollment for six (6) consecutive weeks or more will be required to submit a new application pursuant to Section 2699.6600.

(d) If there is funding available, or there is no funding available for coverage of child-linked adults but the Board estimates that the program will be closed to such new enrollment for less than six (6) consecutive weeks, the application shall be reviewed for completeness pursuant to Section 2699.6606.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21 and 12693.755, Insurance Code.

2699.6606. Review of Applications for Completeness.

(a) All applications and Add a Person Forms shall be reviewed for completeness, except for applications, Add a Person Forms, and documentation solely applicable to childlinked adults if there is no funding available and the Board estimates that the program will be closed to new enrollment for six (6) consecutive weeks or more.

(b) An application that is complete except for documentation required by Section 2699.6600(c)(1)(T) shall be considered complete.

(1) If the application is incomplete, a telephone call will be placed to the applicant to request the missing information and documentation. If the applicant is reached, the applicant will be asked to provide the necessary information and documentation. If the applicant is not reached by telephone, a notice indicating the required information and documentation will be mailed. The applicant must provide all information and documentation necessary for the application to be complete within seventeen (17) calendar days from the date the application was received by the program, and the applicant will be so notified.

(2) If the application submitted is not complete and it is not completed within seventeen (17) calendar days, the application shall be denied. The applicant shall be sent a notice indicating that their application is denied on the basis that the program could not make an eligibility determination because of missing information or documentation.

(3) If the application is complete or is completed within seventeen (17) calendar days, it will be reviewed for an eligibility determination.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Section 12693.21, Insurance Code.

2699.6607. Determination of Eligibility.

(a) Except as specified in Section 2699.6605, the program shall complete the application review process within ten (10) calendar days of receipt of the complete application or Add a Person Form unless the program is waiting for necessary information pursuant to Subsection 2699.6606 (b)(1) and (2). For those applications, the program shall complete the application review process within twenty (20) calendar days of receipt of the original application or Add a Person Form.

(1) The program shall determine eligibility for each person age 18 or under based upon the criteria specified in Insurance Code Sections 12693.70, 12693.73 and 12693.76 and this section.

(2) The program shall determine eligibility for each person age 19 and over based on the criteria specified in this section. Notwithstanding any other provision of this Chapter, the first date on which any person age 19 or over shall be eligible for the program is the parental coverage start date. In addition to the criteria applicable to all potential subscribers, to be a child-linked adult eligible to participate in the program, a person age 19 or over must meet all the following requirements:

(A) Is not eligible for no-cost full-scope, or pregnancy-related, Medi-Cal or Medicare Part A and B at the time of enrollment in the program.

(B) Is a resident of the State of California pursuant to Section 244 of the Government Code; or is physically present in California and entered the state with a job commitment or to seek employment.

(C) Is in a family with an annual or monthly household income after income deductions of up to and including 200 percent of the federal poverty level. Any income deduction that is applicable to a child under Medi-Cal shall be applied in determining the annual or monthly household income.

(D) If a person age 19 or over for whom enrollment in the program is requested has an annual or monthly household income after income deductions of 100 percent of the federal poverty level or below, a letter or Notice of Action from the County Welfare Office issued within the last two (2) months

must state that the individual is not eligible for no-cost Medi-Cal for a reason other than:

1. failure to provide information requested by Medi-Cal or

2. termination from no-cost Medi-Cal at his or her own request.

(E) Notwithstanding 2699.6607(a)(2)(D), legal guardians applying to the program for coverage with an annual household income after income deductions of 100 percent of the federal poverty level or below do not need to provide a Notice of Action from the County Welfare Office.

(F) Meets the definition of child-linked adult as defined in Section 2699.6500.

(G) Has a qualifying event as defined in Section 2699.6500 or applies pursuant to Section 2699.6631 for the first year following the parental coverage start date.

(3) If the program does not have the documentation required by Subsection 2699.6600(c)(1)(T), the person shall be temporarily deemed to meet citizenship or immigration criteria until such documentation is submitted or until the time for submitting documentation established in Subsection 2699.6600(c)(1)(T) has expired, whichever is sooner.

(b) The program shall disregard any stepparent's income in determining income eligibility for a stepchild.

(c) The program shall disregard any child's income in determining income eligibility for any other person.

(d) If any persons for whom application is being made currently have employer sponsored health coverage, these persons shall be determined ineligible. If employer sponsored health coverage was terminated for any persons for whom application is being made within the last three (3) months, these persons shall be determined ineligible, unless the reason for the termination is one of the following:

(1) The person through whom the employer sponsored coverage had been available either

(A) lost employment or experienced a change in employment

status,

(B) changed address to a zip code that is not covered by the employer-sponsored coverage,

(C) lost health benefits because the person's employer discontinued health benefits to all employees or dependents, or ceased to provide coverage or contributions for one or more categories of employees or dependents, or

(D) lost coverage because of death of the individual through whom the children or child-linked adults were covered, or a legal separation or divorce from the individual through whom the children or child-linked adults were covered.

(2) The person for whom application is being made was covered under a COBRA policy, and the COBRA coverage period has ended.

(3) The person for whom application is being made had coverage provided under an exemption authorized under subdivision (i) of Section 1367 of the Health and Safety Code.

(e) (1) Subject to paragraph (2) below, an alien shall only be eligible for the program if the alien is a qualified alien.

(2) (A) In any fiscal year that the annual Budget Act provides the necessary funding, a person who is a qualified alien shall not be determined ineligible solely on the basis on his or her date of entry into the United States. If the annual Budget Act does not provide the necessary funding, and except as provided in subparagraph (B) below, person who is a qualified alien and who entered or enters the United States on or after August 22, 1996, is not eligible for a period of five years beginning on the date of the alien's entry into the United States with a status within the meaning of the term qualified alien.

(B) The limitation under paragraph (2)(A) above shall not apply to the following aliens:

1. An alien who is admitted to the United States as refugee under Section 207 of the Immigration and Naturalization Act (INA).

2. An alien who is granted asylum under Section 208 of the INA.

3. An alien whose deportation is being withheld under Section 243(h) of the INA (8 U.S.C. Section 1230(h)) (as in effect immediately before the effective date (April 1, 1997) of Section 307 of Division (C) of Public Law 104-208) or Section 241(b)(3) of the INA (8 U.S.C. Section 1251(b)(3) (as amended by Section 305(a) of Division C of Public Law 104-208).

4. An alien who is a Cuban and Haitian entrant as defined in Section 501(e) of the Refugee Education Assistance Act of 1980.

5. An alien admitted to the United States as an Amerasian immigrant as described in Section 1612(a)(2)(A)(v.) of Title 8 of the United States Code.

6. An alien who is lawfully residing in any state and is any of the following:

   a. A veteran (as defined in Section 101, 1101, or 1301, or as described in Section 107 of Title 38 of the United States Code) with a discharge characterized as an honorable discharge and not on account of alienage and who fulfills the minimum active-duty service requirement of Section 5303A(d) of Title 38 of the United States Code.

   b. On active duty (other than active duty for training) in the Armed Forces of the United States.

   c. The spouse or unmarried dependent child of an individual described in subparagraph a. or b. or the unremarried surviving spouse of an individual described in subparagraph a. or b. who is deceased if the marriage fulfills the requirements of Section 1304 of Title 38 of the United States Code.

(3) The program shall verify the status of any person for whom application is being made to confirm that the person is a citizen, a non-citizen national of the United States, or a qualified alien.

(f) If application was made pursuant to Section 2699.6603(d), eligibility is

contingent upon receipt by the program of documentation of the child's birth within thirty (30) days of the birth.

(g) Applicants will be notified in writing of the eligibility determination for each person applied for. If a person is determined ineligible the notice shall include the reason for the determination of ineligibility and an explanation of the appeal process. The family contribution for any persons determined ineligible which was included with the application shall be refunded. If appropriate, and if permission is given by the applicant, the application shall be forwarded to the Medi-Cal program for eligibility determination.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.70, 12693.71, 12693.73 and 12693.755, Insurance Code.

2699.6608 Enrollment of AIM Infants.

(a) An AIM infant shall be enrolled when the program receives the required family child contribution beginning with the first full month of coverage pursuant to Section 2699.6613(g), and the following information about the infant from the AIM infant's mother at any time through the end of the eleventh month following the month of birth:

(1) Name; and

(2) Date of birth; and
(3) Sex.

(b) The program shall request information from the AIM infant's mother, on the AIM infant's weight at birth and primary care provider.

(c) In lieu of reporting by the AIM infant's mother, the program must also accept the information specified in subsections (a) and (b) from the AIM infant's mother's health plan or a health care provider that provided services to the AIM infant's mother or the AIM infant.

(d) Upon receipt of the family child contribution and the information specified in subsection (a), the program shall automatically enroll the infant in the same health plan within the Healthy Families Program that the AIM infant's mother is enrolled in through the AIM program.

(e) Automatic enrollment of AIM infants is subject to payment of family child contributions and timely notification of the infant's birth as provided in (a).

(f) Notwithstanding subsection (a) of this section, infants in need of immediate health care services will be immediately enrolled in the

program if: (1) the AIM infant's mother's health plan notifies the program in writing of the need for services and provides the information specified in subsection (a) of this section; and (2) this written notification occurs no later than the 10th day of the second full calendar month of the infant's life. For infants enrolled pursuant to this subsection (f), the required family child contribution shall be billed to the AIM mother. If the required family child contribution is not paid, the provisions of this article concerning disenrollment for failure to pay the required family child contribution shall govern.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.70, 12693.71, 12693.73 and 12693.755 and 12693.765, Insurance Code.

2699.6609. Change of Address.

An applicant shall notify the program in writing within thirty (30) days of any change of the applicant's billing address or any change of residence of a person participating in the program.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Section 12693.21, Insurance Code.

2699.6611. Disenrollment.

(a) A subscriber shall be disenrolled from participation in the program if any of the following occur:

(1) The subscriber is found by the program to no longer be eligible during the annual eligibility review period.

(2) The subscriber child attains the age of 19. A subscriber child who attains the age of 19 will not be disenrolled from the program if he or she applies to the program pursuant to Section 2699.6600 and is determined to be eligible for the program as a subscriber parent pursuant to Section 2699.6607 before his or her effective date of disenrollment.

(3) A subscriber is determined by the program to not be a citizen, non-citizen national, or a qualified alien eligible to participate in the program or fails to provide documentation required pursuant to Subsection 2699.6600(c)(1)(T) within the required time period.

(4) The applicant fails to pay the required family contribution for the

subscriber for two (2) consecutive calendar months.

(5) The applicant so requests in writing on behalf of himself or herself or on behalf of another subscriber for whom he or she applied.

(6) The applicant has intentionally made false declarations in order to establish program eligibility for any person.

(7) The applicant fails to provide the necessary information for the subscriber to be requalified.

(8) Death of a subscriber.

(9) The child through whom the subscriber parent became eligible as a child-linked adult as defined in Section 2699.6500 is no longer enrolled in no-cost Medi-Cal and has not enrolled in the program.

(10) The child through whom the subscriber parent became eligible as a child-linked adult as defined in Section 2699.6500 did not enroll in no-cost Medi-Cal, or the program, and the subscriber parent has no other children enrolled in the program or no-cost Medi-Cal.

(11) The child through whom the subscriber parent became eligible as a child-linked adult as defined in Section 2699.6500 attains the age of 19 and the subscriber parent has no other children enrolled in the program or no cost Medi-Cal.

(12) The child through whom the subscriber parent became eligible as a child-linked adult as defined in Section 2699.6500 no longer lives with the subscriber parent and another adult with whom the child now lives applies and is found eligible for enrollment as a child-linked adult through the same child.

(13) The child through whom the subscriber parent became eligible as a child-linked adult as defined in Section 2699.6500 is no longer enrolled in the program, and the subscriber parent has no other children enrolled in the program or no-cost Medi-Cal.

(b) Prior to disenrolling a subscriber pursuant to (a)(4), the program shall provide written notification to the applicant no less than thirty (30) days prior to disenrollment. Such notice shall clearly indicate all of the following:

(1) The disenrollment will not occur if payment in full is made as required.

(2) If disenrollment for non-payment occurs, coverage will be terminated at the end of the second consecutive month for which the family contribution was not paid.

(c) When a subscriber is disenrolled pursuant to (a) above, the program shall notify the applicant of the disenrollment. The notice shall be in writing and include the following information:

(1) The reason for the disenrollment.

(2) The effective date of disenrollment.

(3) The final day of coverage provided through the program.

(4) An explanation of the appeals process including the right to request continued enrollment pursuant to Section 2699.6612.

(d) Disenrollment pursuant to (a)(4) shall be effective as of the end of the second consecutive calendar month for which the required monthly contributions were not paid in full.

(e) Disenrollment pursuant to (a)(7) shall be effective at the end of the month of the subscriber's anniversary date.

(f) Disenrollment pursuant to (a)(1) shall be effective two (2) months after the end of the month of the subscriber's anniversary date if the subscriber is no longer eligible for the program because his or her household income is below the program guidelines. Otherwise, disenrollment pursuant to (a)(1) shall be effective at the end of the month of the subscriber's anniversary date.

(g) Disenrollment pursuant to (a)(3) shall be effective at the end of the calendar month in which the conclusion of the two-month period falls pursuant to Subsection 2699.6600(c)(1)(T).

(h) Disenrollment pursuant to (a)(5) shall be effective at the end of the month in which the applicant's request was received. The applicant will be notified of the amount of family contribution due to the program for coverage through the subscriber's effective date of disenrollment.

(i) Disenrollment pursuant to (a)(6) shall be effective at the end of the month in which the determination was made.

(j) Disenrollment pursuant to (a)(2) and (a)(11) shall be effective on the last day of the month the subscriber child or the child through whom the subscriber parent became eligible as a child-linked adult attains the age of 19.

(k) Disenrollment pursuant to (a)(8) shall be effective at the end of the month in which death occurred.

(l) Disenrollment pursuant to (a)(9) shall be effective at the end of the month following the program's notification of the subscriber child's disenrollment from no-cost Medi-Cal.

(m) Disenrollment pursuant to (a)(10) shall be effective at the end of the month following the second month from the date in which the application was received.

(n) Disenrollment pursuant to (a)(12) shall be effective at the end of the month following the program's determination that the subscriber child has departed from the subscriber parent's household and is living with another adult who has applied for enrollment and is eligible as a child-linked adult through that same child.

(o) Disenrollment pursuant to (a)(13) shall be effective at the end of the month following the program's determination that the adult is no longer child linked.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.45, 12693.74, 12693.77, 12693.755, 12693.98 and 12693.981, Insurance Code.

2699.6612. Appeals.

(a) The following program decisions may be appealed to the board:

(1) A decision that an individual is not qualified to participate or continue to participate in the program.

(2) A decision that an individual is not eligible for enrollment or continuing enrollment in the program.

(3) A decision as to the effective date of coverage.

(b) An appeal shall be filed in writing with the program within sixty (60) calendar days of the date of the notice of the decision being appealed.

(c) Appeals shall be reviewed pursuant to the following process:

(1) First level appeals shall be filed with the program, and the program shall make a determination on the appeal within thirty (30) calendar days from receipt of the appeal. The program shall notify the

appellant in writing of the program's decision and that he or she may request a second level review by the Executive Director.

(2) Second level appeals shall be filed with the Executive Director within thirty (30) calendar days of the date of the notice of the determination concerning the first level appeal. The program may contact the appellant to get clarification and additional information to make a determination. The program shall notify the appellant in writing of the Executive Director's decision and that he or she may request an administrative hearing.

(3) As determined by the program, an administrative hearing shall be conducted by an Administrative Law Judge employed by the Office of Administrative Hearings pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, or pursuant to the pre-and post-hearing procedures set forth in Article 3 (commencing with Section 1140) of Chapter 2 of Division 2 of Title 1 of the California Code of Regulations as modified by Section 12693.89 of the Insurance Code. Requests for administrative hearings shall be filed with the program within thirty (30) calendar days of receipt of the determination concerning the second level appeal.

(d) An appeal shall include all of the following:

(1) A copy of any decision being appealed, or a written statement of the action or failure to act being appealed.

(2) A statement describing the issues that are being disputed.

(3) A statement describing the program statute, regulation, or other written representation of program policy that the program or board violated.

(4) A statement of the resolution being requested.

(5) Any other relevant information.

(e) An appellant may request continued enrollment while the appeal is being determined. The enrollment shall continue until a determination is made. Family contributions and copays are required during the continued enrollment period. An appeal that requests continued enrollment shall:

(1) Be limited to appeals filed pursuant to subsection (c)(1) of this section.

(2) Be filed in writing with the program within fifteen (15) calendar days of the date the notice of the decision being appealed.

(3) Meet all other requirements described in this section.

NOTE: Authority cited: Sections 12693.21 and 12693.41, Insurance Code. Reference: Sections 12693.85, 12693.86, 12693.87, and 12693.89, Insurance Code and 42 CFR Section 457.1170.

2699.6613. Starting Date of Coverage For Subscribers.

(a) Coverage shall begin for subscribers no later than ten (10) calendar days from the date the person is determined to be eligible unless any of the following applies:

(1) A person for whom application is being made is eligible for continued eligibility under no-cost, full scope Medi-Cal and that eligibility will continue for more than ten (10) calendar days from the date the person is determined to be eligible.

(2) Application is being made on behalf of a child less than 12 months of age for coverage to begin on the child's first birthday pursuant to Section 2699.6603(a).

(3) Application is being made on behalf of a child who is currently enrolled in the Medi-Cal 133 percent program.

(4) Application is being made on behalf of a newborn prior to birth.

(5) Payment of in arrears family contributions is required prior to enrollment of the person pursuant to Section 2699.6600(a)(4) or (5).

(6) The subscriber is an AIM infant.

(b) Coverage shall begin for subscribers under (a)(1) on the first day after the end of the subscriber's continued eligibility period under Medi-Cal.

(c) Coverage shall begin for subscribers under (a)(2) on their first birthday.

(d) Coverage shall begin for subscribers under (a)(3) on their sixth birthday.

(e) Coverage shall begin for subscribers under (a)(4) no less than eleven (11) calendar days but within thirteen (13) calendar days after the program receives documentation of the birth.

(f) Coverage shall begin for subscribers under (a)(5) no later than thirteen 13

calendar days from the date the program receives a payment for the complete amount of family contributions owed by the applicant.

(g) Coverage shall begin for subscribers pursuant to (a)(6) on the infant's date of birth.

(h) The program shall notify applicants in writing of the effective date of coverage for all persons determined to be eligible.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21, Insurance Code.

2699.6617. Additional Enrollments.

(a) To apply to the program for additional persons, the applicant shall submit an application pursuant to Section 2699.6600 or the "Add a Person Form" (HF FM 067 EN, 11/17/2003), which requests information pursuant to Section 2699.6600(b), 6600(c)(1)(A), (D), (F)1., (F)3., (F)11., (F)15., (I), (K), (L), (R), (S), and (T).

(b) Eligibility for the program will be determined pursuant to Section 2699.6607.

(c) The "Add a Person Form" (HF FM 067 EN,11/17/2003), is hereby incorporated by reference.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Section 12693.21, Insurance Code.

2699.6619. Transfer of Enrollment.

(a) A subscriber shall be transferred from one participating health, dental, or vision plan to another if any of the following occurs:

(1) The applicant so requests in writing because the subscriber no longer resides in an area served by the participating plan in which the subscriber is enrolled, and there is at least one participating plan serving the area in which the subscriber now resides.

(A) If the program learns that the subscriber no longer resides in an area served by the participating health plan in which the subscriber is enrolled, but the applicant does not choose a new health plan within thirty (30) days of a written notice from the program, the program will enroll the subscriber in the Community Provider Plan in the subscriber's county of residence.

(B) If the program learns that the subscriber no longer resides in an area served by the participating dental plan in which the subscriber is enrolled, but the applicant does not choose a new dental plan within thirty (30) days of a written notice from the program, the program will enroll the subscriber in a participating dental plan in the subscriber's county of residence. If there is more than one (1) participating dental plan in the subscriber's county of residence, the program will alternate assignments between the participating dental plans so that the transfers are evenly distributed among the participating dental plans.

(C) If the program learns that the subscriber no longer resides in an area served by the participating vision plan in which the subscriber is enrolled, but the applicant does not choose a new vision plan within thirty (30) days of a written notice from the program, the program will enroll the subscriber in a participating vision plan in the subscriber's county of residence. If there is more than one (1) participating vision plan in the subscriber's county of residence, the program will alternate assignments between the participating vision plans so that the transfers are evenly distributed among the participating vision plans.

(2) The applicant or the participating plan so requests in writing because of failure to establish a satisfactory subscriber-plan relationship and the Executive Director of the Board or designee determines that the transfer is in the best interests of the subscriber and the program, and there is at least one other participating plan serving the area in which the subscriber resides.

(3) The program contract with the participating plan in which the subscriber is enrolled is canceled or not renewed.

(A) If the applicant does not choose a new health plan in response to two (2) written notices and three (3) phone calls from the program by the necessary date of transfer, the program will enroll the subscriber in the Community Provider Plan in the subscriber's county of residence.

(B) If the applicant does not choose a new dental plan in response to two (2) written notices and three (3) phone calls from the program by the necessary date of transfer, the program will enroll the subscriber in a participating dental plan in the subscriber's county of residence. If there is more

than one (1) participating dental plan in the subscriber's county of residence, the program will alternate assignments between the participating dental plans so that the transfers are evenly distributed among the participating dental plans.

(C) If the applicant does not choose a new vision plan in response to two (2) written notices and three (3) phone calls from the program by the necessary date of transfer, the program will enroll the subscriber in a participating vision plan in the subscriber's county of residence. If there is more than one (1) participating vision plan in the subscriber's county of residence, the program will alternate assignments between the participating vision plans so that the transfers are evenly distributed among the participating vision plans.

(4) An open enrollment request is submitted pursuant to Section 2699.6621.

(5) An AIM infant subscriber has a sibling(s) that is enrolled in a different health plan and is transferred pursuant to subsection (e).

(b) A subscriber shall be transferred from one participating health, dental, or vision plan to another if the applicant so requests in writing once within the first three (3) months from the original effective date of coverage in the program, or the applicant so requests in writing once within the first thirty (30) days from the effective date of coverage in a new plan following open enrollment, for any reason.

(c) If a subscriber is transferred pursuant to (a) or (b) above, all other subscribers of the same applicant who live in the same household will also be transferred, unless the subscriber was transferred because the subscriber moved from the household.

(d) Transfer of enrollment shall take effect on the first day of a month and shall be within forty (40) days of approval of the request, or, if the transfer is pursuant to subsection (a)(3) above, shall take effect prior to the end of the contract. However, subscribers in inpatient facilities on the scheduled date of transfer shall not be transferred to a new health plan until the first day of the month following completion of their inpatient stay.

(e) The following provisions apply to the transfer of AIM infants from one participating health, dental, or vision plan to another:

(1) An AIM infant subscriber will be automatically transferred to the same health, dental, and vision plan that his or her sibling(s) is

enrolled in, effective on the first day of the infant's third calendar month of birth, unless one of the following occurs:

(A) The applicant submits a letter stating that the infant has a physical, developmental, behavioral, or emotional condition that requires continuity of care, and requests that the infant's sibling(s) be transferred to the infant's health plan, or

(B) The applicant submits a letter stating that the infant has a physical, developmental, behavioral, or emotional condition that requires continuity of care, and requests that the infant remain with the current health plan and the sibling(s) remain with his or her current health plan. For siblings enrolled in different health plans, the applicant must choose the same health plan for all children living in the household during the Open Enrollment period after the AIM infant's first birthday.

(2) An AIM infant subscriber shall be transferred from one participating health, dental, or vision plan to another if the applicant so requests in writing once within the first three (3) months from the date of the infant's birth and the infant subscriber has no sibling(s) in the program. The transfer of enrollment shall take effect on the first day of a month and shall be within forty (40) days after the approval of the request but not earlier than the third calendar month of the infant's enrollment in the program.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21, 12693.326 and 12693.51, Insurance Code.

2699.6621. Open Enrollment Period.

(a) The program shall provide for an annual open enrollment period of at least forty-five (45) calendar days. During this period, applicants may for any reason request that subscribers be transferred from one participating health, dental, or vision plan to another. Plan selection rules set forth in Section 2699.6623 apply for open enrollment.

(b) For each subscriber for whom an applicant is requesting to change plans during an open enrollment period, the applicant shall provide the following:

(1) Full name

(2) Address

(3) Social Security Number (optional)

(4) Home telephone number

(5) Current participating plan(s)

(6) New participating plan(s)

(7) The applicant's choice of primary care provider/clinic (optional) and dentist (optional) for each child for whom application is being made.

(8) A declaration that the applicant understands that a change of participating plans may result in a change in the required family contribution.

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Sections 12693.21, 12693.51, Insurance Code.

2699.6623. Choosing Plans.

(a) If all persons for whom the applicant applies live in the same household, the applicant shall enroll all persons in the same participating health plan, the same participating dental plan, and the same participating vision plan.

(b) If the persons for whom the applicant applies live in more than one household, the applicant shall enroll all persons living in each household in the same participating health plan, the same participating dental plan and the same participating vision plan.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21, Insurance Code.

2699.6625. Annual Eligibility Review for Subscribers.

(a) Except as specified in (c), each subscriber will be re-evaluated annually prior to his or her anniversary date in the program to determine continued eligibility for the program. Applicants shall be notified of the annual eligibility review process at least sixty (60) calendar days prior to the anniversary date.

(b) Notwithstanding (a), as a condition of continuing coverage beyond the age of twelve (12) months, an applicant who enrolls an AIM infant into the program after nine months of age shall provide the information necessary to determine the infant's eligibility for ongoing coverage after the age of twelve (12) months at the time of enrollment.

(c) If subscribers for whom an applicant has applied have different anniversary dates, the annual eligibility review will be based on the anniversary date of the last subscriber to be enrolled, except as described in Subsection 2699.6631(f).

(d) To requalify, an applicant must provide to the program all of the following information which is required to reestablish eligibility: the applicant's name and account number as stated on their billing statement; name and address of each enrolled person, documentation of gross income of each enrolled person's household as described in Subsection 2699.6600(c)(1)(K), documentation of court ordered child support, and/or alimony paid, and child care and/or disabled dependent care expenses paid in order to determine income deductions as described in Subsection 2699.6600(c)(1)(L), an indication of any pregnant family member living in the home and her expected due date, and a statement indicating which person(s) is currently enrolled in an employer sponsored health insurance plan. To avoid a break in coverage, all required information must be submitted at least ten (10) calendar days before the end of the month in which the anniversary date falls.

(e) Continued eligibility will be determined pursuant to Section 2699.6607.

(f) Unless disenrolled pursuant to Section 2699.6611, persons shall continue to be considered eligible for the program for one year from the effective date of coverage, or if a later annual eligibility review date is established under (c), until that date.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21, 12693.74 Insurance Code.

2699.6629. Payment for Application Assistance.

(a) The program shall pay an application assistance fee to an eligible entity that assists an applicant in completing a program application or assists an applicant in completing annual eligibility review, if the following conditions are met:

(1) A child or a child-linked adult are enrolled or requalified as a result of the application;

(2) The request for payment is made in writing and specifies the entity to which the payment shall be made and includes:

(A) The certified application assistant identification number of the person who assisted the applicant.

(B) The entity identification number.

(3) The application includes a signed and dated declaration by the applicant stating that the certified application assistant helped the applicant complete the application.

(4) The certified application assistant has successfully completed a state-sponsored or approved training course, which may include continuing education courses.

(b) The following entities are eligible to receive application assistance fees:

(1) an insurance agent as defined in Section 31 of the Insurance Code, or a broker as defined in Section 33 of the Insurance Code;

(2) a licensed health care provider;

(3) a tax preparer as defined in Section 22251 (a)(1)(A) of the Business and Professions Code;

(4) a licensed health care institution;

(5) a licensed health care clinic;

(6) a county department of public health, a city health department, or a county department that delivers health services;

(7) an Indian Health Service Facility;

(8) a school;

(9) a faith-based organization;

(10) a licensed day-care provider;

(11) a direct state Maternal and Child Health Contractor;

(12) a WIC Supplemental Food and Nutrition program for Women, Infants and Children;

(13) a Parent Teacher Organization;

(14) An organization meeting all of the following criteria:

(A) The organization has significant interaction with children or parents of children who represent the target market for the program or for children's Medi-Cal;

(B) The organization is not a licensed health, dental or vision plan, or an organization providing health, dental or vision care to children; and

(C) The organization has a federal tax identification number and is a bona fide non-profit entity as determined by the Internal Revenue Service.

(c) An incomplete request will not be processed for reimbursement; missing information cannot be submitted at a later date.

(d) The amount of the application assistance fee shall be as follows:

(1) Fifty ($50.00) dollars per successful application made pursuant to Section 2699.6600 where a child successfully enrolls in no-cost Medi-Cal or the program.

(2) Fifty ($50.00) dollars per successful application made pursuant to Section 2699.6600 where a child-linked adult successfully enrolls in no-cost Medi-Cal or the program when a request for enrollment is made at the same time for the child through whom the subscriber parent became eligible as a child-linked adult as defined in Section 2699.6500.

(3) If children or child-linked adults on one application are enrolled in no-cost Medi-Cal and the program, a $50.00 payment will be made for each program pursuant to (1) and (2).

(4) Payment will only be made on one successful application for no-cost Medi-Cal and one successful application for the program per enrollment entity for a household in a year.

(5) Twenty-five ($25.00) dollars for a successful Annual Eligibility Review for the program.

(e) The program shall monitor the payment of application assistance fees to assure the integrity of the process.

(1) The program may determine at any time that an individual will no longer be eligible to be a certified application assistant and/or an entity will no longer be eligible to receive application assistance fees.

(2) Notice of such determination shall be provided within five (5) calendar days.

(f) Entities applying for application assistance fees and certified application assistants are prohibited from assisting applicants in choosing a health, dental, or vision plan for persons for whom application is being made. The person or entity may direct the applicant to that part of the program materials that describes health, dental, and vision plans. Nothing in this subdivision shall be construed to prohibit an application assistant or entity from providing factual information comparing, contrasting, and explaining the differences between plans and/or provider networks when assisting an applicant. In no instance may an application assistant or entity suggest which plan or provider an applicant should choose.

(g) Participating dental and vision plans shall be prohibited from directly, indirectly, or through their agents conducting in-person, door-to-door, mail, or phone solicitation of applicants for enrollment, or from assisting applicants to apply for the program except as permitted by California Insurance Code Section 12693.325.

(h) Participating health plans shall be prohibited from directly, indirectly, or through their agents conducting in-person, door-to-door, mail, or phone solicitation of applicants for enrollment, or from assisting applicants to apply for the program except as permitted by California Insurance Code Section 12693.325.

(i) Nothing in this section shall prohibit licensed health, dental or vision care providers who are not claiming an application assistance fee from otherwise distributing program applications and providing assistance to applicants.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.32, 12693.325 and 12693.755, Insurance Code.

2699.6631. Initial Enrollment Period for Child-linked Adults.

There shall be an initial enrollment period for child linked adults ending one year after the parental coverage start date. Thereafter, enrollment may only occur at a qualifying event as defined in Section 2699.6500.

(a) The program shall provide notification to the applicants of subscriber children enrolled prior to the parental coverage start date in households with incomes at or below 200 percent of the federal poverty level. Notification shall be sent to the address on record and shall include an explanation of program expansions to include child-linked adults, and instructions to complete and return to the program the form provided by

the program, documentation of citizenship or immigration status pursuant to 2699.6600(c)(1)(T), and the appropriate family contribution for enrollment.

(b) For the first year following the parental coverage start date, for all applications for the program for children only where one or more children enrolled in the program live in households with incomes at or below 200 percent of the federal poverty level, the applicant shall be notified of program expansions to include child-linked adults and shall be provided the opportunity to submit the additional information to the program. The notification shall include instructions to complete and return to the program the form provided by the program, documentation of citizenship or immigration status pursuant to 2699.6600(c)(1)(T), and the appropriate family contribution for enrollment.

(c) For the first year following the parental coverage start date, the applicant shall be provided the opportunity to submit the form provided by the program pursuant to this section and the appropriate family contribution. Beginning one year after the parental coverage start date, applicants must use an application or an Add a Person Form to request enrollment for a child or child-linked adult in the program.

(d) Except as provided in this section, the program shall determine eligibility and enroll child-linked adults pursuant to the process established for application to the program.

(e) Notwithstanding Section 2699.6625(e), the annual eligibility review date for the subscriber parent enrolled pursuant to Section 2699.6631 shall be the same as for the subscriber child through whom the subscriber parent became eligible.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21 and 12693.755, Insurance Code.

ARTICLE 3: HEALTH, DENTAL AND VISION BENEFITS

2699.6700. Scope of Health Benefits.

(a) The basic scope of benefits offered by participating health plans must comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975 including amendments as well as its applicable regulations, and shall include all of the benefits and services listed in this section, subject to the exclusions listed in this section and Section 2699.6703. No other benefits shall be permitted to be offered by a participating health plan as part of the program. The basic scope of benefits shall include:

(1) Health Facilities

(A) Inpatient Hospital Services: General hospital services, in a room of two or more, with customary furnishings and equipment, meals (including special diets as medically necessary), and general nursing care. All necessary ancillary services such as: use of operating room and related facilities; intensive care unit and services; drugs, medications, and biologicals; anesthesia and oxygen; diagnostic laboratory and x-ray services; special duty nursing; physical, occupational, and speech therapy , respiratory therapy; administration of blood and blood products; other diagnostic, therapeutic and rehabilitative services as appropriate; and coordinated discharge planning, including the planning of such continuing care as may be necessary.

Exclusions: Personal or comfort items or a private room in a hospital are excluded unless medically necessary.

(B) Outpatient Services: Diagnostic, therapeutic and surgical services performed at a hospital or outpatient facility. Includes hospital services which can reasonably be provided on an ambulatory basis and related services and supplies in connection with these services including operating room, treatment room, ancillary services, and medications which are supplied by the hospital or facility for use during the subscriber’s stay at the facility. Includes physical, occupational, and speech therapy, if necessary.

(C) Inpatient and Outpatient Services include coverage for general anesthesia and associated facility charges, and outpatient services in connection with dental procedures when the use of a hospital or surgery center is necessary

because of the subscriber's medical condition or clinical status or because of the severity of the dental procedure. This benefit is only available to subscribers under seven years of age; the developmentally disabled, regardless of age; and subscribers whose health is compromised and for whom general anesthesia is medically necessary, regardless of age.

Participating health plans shall coordinate such services with the subscriber's participating dental plan. Services of the dentist or oral surgeon for dental procedures are excluded.

(2) Professional Services: Services and consultations by a physician or other licensed health care provider acting within the scope of his or her license. Includes services of a surgeon, assistant surgeon and anesthesiologist (inpatient or outpatient); inpatient hospital and skilled nursing facility visits; professional office visits including visits for examinations, allergy tests and treatments, radiation therapy, chemotherapy, and dialysis treatment; specialist office visits, and home visits.

(3) Preventive Services: Services for the detection and treatment of asymptomatic diseases including:

(A) Vision Services: For subscriber children, vision testing, eye refractions to determine the need for corrective lenses, and dilated retinal eye exams. For subscriber parents, eye refraction is optional for plan. Includes cataract spectacles, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery. Also one pair of conventional eyeglasses or conventional contact lenses are covered if necessary after cataract surgery with insertion of an intraocular lens.

(B) Hearing Services: Includes hearing testing, an audiological evaluation to measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid.

Hearing Aid: Monaural or binaural hearing aids including ear mold(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment. Visits for fitting, counseling, adjustments, repairs, etc, at no charge for a one-year period following the provision of a covered hearing aid.

Limitation: For subscriber parents, this benefit is limited to a maximum of $1000 per member every thirty-six months for the hearing instrument and ancillary equipment.

Exclusions: The purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase, charges for a hearing aid which exceeds specifications prescribed for correction of a hearing loss replacement parts for hearing aids, repair of hearing aid after the covered one-year warranty period, replacement of a hearing aid more than once in any period of thirty-six months, and surgically implanted hearing devices.

(C) Immunizations for Subscriber Children: Immunizations consistent with the most current version of the Recommended Childhood Immunization Schedule/United States adopted by the Advisory Committee on Immunization Practices (ACIP). Includes immunizations required for travel as recommended by the ACIP, and other age appropriate immunizations as recommended by the ACIP.

Immunizations for Subscriber Parents: Immunizations for adults as recommended by the ACIP. Immunizations required for travel as recommended by the ACIP. Immunizations such as Hepatitis B for individuals at occupational risk, and other age appropriate immunizations as recommended by the ACIP.

(D) Periodic Health Examinations: For subscriber children, periodic health examinations, including all routine diagnostic testing and laboratory services appropriate for such examinations consistent with the most current Recommendations for Preventative Pediatric Health Care, as adopted by the American Academy of Pediatrics;

The frequency of such examinations shall not be increased for reasons which are unrelated to the medical needs of the subscriber including: a subscriber's desire for physical examinations; or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance.

Periodic Health Examinations for Subscriber Parents: Periodic health examinations including all routine diagnostic testing and laboratory services appropriate for such examinations. This includes coverage for the screening and

diagnosis of prostate cancer including but not limited to, prostate-specific antigen testing and digital rectal examination, when medically necessary and consistent with good medical practice. The frequency of such examinations shall not be increased for reasons which are unrelated to the medical needs of the subscriber including: a subscriber's desire for physical examinations; or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance.

(E) Well Baby Care during the first two years of life, including newborn hospital visits, health examinations and other office visits.

(F) Family Planning Services: Voluntary family planning services including, counseling and surgical procedures for sterilization as permitted by state and federal law, diaphragms, and coverage for other federal Food and Drug Administration approved devices and contraceptive drugs pursuant to the prescription drug benefit.

(G) Maternity Services: Professional and hospital services relating to maternity care including pre-natal and postpartum care and complications of pregnancy, prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy, labor and delivery care, newborn examinations and nursery care while the mother is hospitalized, and coverage for participation in the statewide prenatal testing program administered by the State Department of Health Services known as the Expanded Alpha Feto Protein Program.

(H) Sexually Transmitted Disease (STD) Testing and Treatment.

(I) Health Education Services: Includes information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services. Includes diabetes outpatient self-management training, education, and medical nutrition therapy necessary to enable a subscriber to properly use equipment and supplies provided for the management and treatment of insulin-using diabetes, non-insulin using diabetes, and gestational diabetes.

(J) Cytology Examinations on a reasonable periodic basis.

(K) Gynecological Examinations: Yearly pelvic examination, Pap smear, breast exam, and any other gynecological service as appropriate.

(L) Cancer Screening: Medically accepted cancer screening tests including, but not limited to, breast, prostate, and cervical cancer screening.

(4) Diagnostic Laboratory Services: Diagnostic laboratory services, diagnostic imaging, and diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, treat, and follow-up on the care of subscribers. Other diagnostic services, which shall include, but not be limited to, electrocardiography, electro-encephalography, and mammography for screening or diagnostic purposes. Laboratory tests appropriate for the management of diabetes, including at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL and Hemoglobin A-1C (Glycohemoglobin).

(5) Prescription Drugs: Drugs when prescribed by a licensed practitioner acting within the scope of his or her licensure. Includes injectable medication, and needles and syringes necessary for the administration of the covered injectable medication.

Insulin, glucagon, syringes and needles and pen delivery systems for the administration of insulin, blood glucose testing strips, ketone urine testing strips, lancets and lancet puncture devices in medically appropriate quantities for the monitoring and treatment of insulin dependent, noninsulin dependent and gestational diabetes.

Prenatal vitamins and fluoride supplements included with vitamins or independent of vitamins require a prescription.

All FDA approved oral and injectable contraceptive drugs and prescription contraceptive devices are covered including internally implanted time release contraceptives.

One cycle or course of treatment of tobacco cessation drugs per benefit year. The health plan must also require the subscriber to attend tobacco use cessation classes or programs in conjunction with tobacco cessation drugs.

For subscriber parents, plans can require subscribers to pay a portion or all the cost of the smoking cessation classes or programs. Plans can also require the subscriber parent to pay the

cost of the smoking cessation drug initially and reimburse the subscriber parent minus the copayment(s) upon the successful completion of a smoking cessation program.

Drugs administered while a subscriber is a patient or resident in a rest home, nursing home, convalescent hospital or similar facility when prescribed by a plan physician in connection with a covered service and obtained through a plan designated pharmacy.

Health plans may specify that generic equivalent prescription drugs must be dispensed if available, provided that no medical contraindications exist. The use of a formulary, maximum allowable cost (MAC) method, and mail order programs by health plans is encouraged.

Exclusions: Experimental or investigational drugs; drugs or medications prescribed solely for cosmetic purposes; patent or over-the-counter medicines, including nonprescription contraceptive jellies, ointments, foams, condoms, etc., even if prescribed by a doctor; medicines not requiring a written prescription order (except insulin and smoking cessation drugs as previously described); and dietary supplements (except for formulas or special food products to treat phenylketonuria or PKU); and appetite suppressants or any other diet drugs or medications, unless necessary for the treatment of morbid obesity.

(6) Durable Medical Equipment: Medical equipment appropriate for use in the home which: 1) is intended for repeated use; 2) is generally not useful to a person in the absence of illness or injury; and 3) primarily serves a medical purpose. The health plan may determine whether to rent or purchase standard equipment. Repair or replacement is covered unless necessitated by misuse or loss.

Includes oxygen and oxygen equipment; blood glucose monitors and blood glucose monitors for the visually impaired as medically appropriate for insulin dependent, non-insulin dependent, and gestational diabetes; insulin pumps and all related supplies; visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin; apnea monitors; podiatric devices to prevent or treat diabetes complications; pulmoaides and related supplies; nebulizer machines, face masks, tubing and related supplies, peak flow meters and spacer devices for metered dose inhalers; ostomy bags and urinary catheters and supplies.

Exclusions: Coverage for comfort or convenience items; disposable supplies except ostomy bags and urinary catheters and supplies

consistent with Medicare coverage guidelines; exercise and hygiene equipment; experimental or research equipment; devices not medical in nature such as sauna baths and elevators, or modifications to the home or automobile; deluxe equipment; or more than one piece of equipment that serve the same function.

(7) Orthotics and Prosthetics: Orthotics and prosthetics including replacement prosthetic devices, and replacement orthotic devices when prescribed by a licensed provider acting within the scope of his or her licensure. Coverage for the initial and subsequent prosthetic devices and installation accessories to restore a method of speaking incident to a laryngectomy, and therapeutic footwear for diabetics. Also includes prosthetic devices to restore and achieve symmetry incident to mastectomy.

Exclusions: Corrective shoes and arch supports, except for therapeutic footwear and inserts for individuals with diabetes; non-rigid devices such as elastic knee supports, corsets, elastic stockings, and garter belts; dental appliances; electronic voice producing machines; or more than one device for the same part of the body. Also does not include eyeglasses (except for eyeglasses or contact lenses necessary after cataract surgery).

(8) Medical Transportation Services: Emergency ambulance transportation in connection with emergency services to the first hospital which actually accepts the subscriber for emergency care. Includes ambulance and ambulance transport services provided through the “911” emergency response system.

Non-emergency transportation for the transfer of a subscriber from a hospital to another hospital or facility or facility to home when the transportation is:

(A) Medically necessary, and

(B) Requested by a plan provider, and

(C) Authorized in advance by the participating health plan.

Exclusions: Coverage for public transportation, including transportation by airplane, passenger car, taxi or other form of public conveyance.

(9) Emergency Health Care Services: Twenty-four hour emergency care for a medical or psychiatric condition, including active labor or severe pain, manifesting itself by acute symptoms of a sufficient

severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(A) Serious jeopardy to the patient's health, or

(B) Serious impairment to bodily functions, or.

(C) Serious dysfunction of any bodily organ or part.

Coverage must be provided both inside and outside of the health plan's service area and in participating and non-participating facilities.

(10) Mental Health

(A) Inpatient: Mental health care during a certified confinement in a participating hospital when ordered and performed by a participating mental health provider for the treatment of a mental health condition. For subscriber children determined by their county mental health department to meet the criteria for Serious Emotional Disturbances (SED) of a child or for a serious mental disorder, pursuant to Section 5600.3 of the Welfare and Institutions Code, plans may limit services to 30 days per benefit year.

Plans shall be responsible for identifying subscriber children who may have a Serious Emotional Disturbances (SED) condition, as defined in California Health and Safety Code section 1374.72, or may have a serious mental disorder, as defined in Welfare and Institutions Code section 5600.3, and shall refer these individuals to their respective county mental health department for evaluation. For subscriber children who are determined to have a SED condition or a serious mental disorder by their county mental health department, participating plans shall provide up to 30 days of inpatient care, including related professional services. After 30 days, the responsibility for providing inpatient and related professional services for continued treatment of the condition will transfer to the county mental health department. The plan and the county shall coordinate services for the subscriber.

Except as limited pursuant to the previous paragraph for subscribers who are determined to have a SED condition or a serious mental disorder by their county mental health department, plans must provide services with no inpatient

day limits for severe mental illnesses including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.

Plans may limit inpatient coverage to 30 days per benefit year for illnesses that meet neither the criteria for severe mental illnesses nor the criteria for SED of a child or for a serious mental disorder.

Plans, with the agreement of the subscriber or applicant or other responsible adult if appropriate, may substitute for each day of inpatient hospitalization any of the following: two (2) days of residential treatment, three (3) days of day care treatment, or four (4) outpatient visits.

(B) Outpatient: Mental health care when ordered and performed by a participating mental health provider. This includes the treatment of children who have experienced family dysfunction or trauma, including child abuse and neglect, domestic violence, substance abuse in the family, or divorce and bereavement. Family members may be involved in the treatment to the extent the plan determines it is appropriate for the health and recovery of the child.

Plans must provide services with no visit limits for severe mental illnesses, including schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa and bulimia nervosa.

Plans shall be responsible for identifying subscriber children who may have a Serious Emotional Disturbances (SED) condition, as defined in California Health and Safety Code section 1374.72, or may have a serious mental disorder, as defined in Welfare and Institutions Code section 5600.3, and shall refer these individuals to their county mental health department for evaluation. Notwithstanding the first sentence of the previous paragraph, participating plans shall refer subscriber children who are determined by their county mental health department to have a SED or a serious mental disorder, to their county mental health department for treatment of the condition. For subscriber children who are determined to have a SED condition or a serious mental

disorder by their county mental health department, outpatient and related professional services pertaining to the condition will be provided by the county mental health department. The plan and the county shall coordinate services for the subscriber.

Plans must provide up to 20 visits per benefit year for illnesses that meet neither the criteria for severe mental illnesses, nor the criteria for SED of a child or a serious mental disorder.

Participating plans may elect to provide additional visits. Plans may provide group therapy at a reduced copayment.

(11) Alcohol and Drug Abuse Services:

(A) Inpatient: Hospitalization for alcoholism or drug abuse to remove toxic substances from the system.

(B) Outpatient: Crisis intervention and treatment of alcoholism or drug abuse on an outpatient basis.

Participating health plans shall provide at least 20 visits per benefit year. Participating health plans may elect to provide additional visits.

(12) Home Health Services: Health services provided at the home by health care personnel. Includes visits by Registered Nurses, Licensed Vocational Nurses, and home health aides; physical, occupational and speech therapy; and respiratory therapy when prescribed by a licensed practitioner acting within the scope of his or her licensure.

Home health services are limited to those services that are prescribed or directed by the attending physician or other appropriate authority designated by the plan. If a basic health service can be provided in more than one medically appropriate setting, it is within the discretion of the attending physician or other appropriate authority designated by the plan to choose the setting for providing the care. Plans shall exercise prudent medical case management to ensure that appropriate care is rendered in the appropriate setting. Medical case management may include consideration of whether a particular service or setting is cost-effective when there is a choice among several medically appropriate alternative services or settings.

Exclusions: Custodial care

(13) Skilled Nursing Care: Services prescribed by a plan physician or nurse practitioner and provided in a licensed skilled nursing facility. Includes skilled nursing on a 24-hour per day basis; bed and board; x-ray and laboratory procedures; respiratory therapy; physical, occupational and speech therapy; medical social services; prescribed drugs and medications; medical supplies; and appliances and equipment ordinarily furnished by the skilled nursing facility. This benefit shall be limited to a maximum of 100 days per benefit year.

Exclusions: Custodial care.

(14) Physical, Occupational, and Speech Therapy: Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility or home. Plans may require periodic evaluations as long as therapy is provided.

(15) Acupuncture and Chiropractic: These are optional benefits which plans may offer. If offered, the plan must provide a self referral benefit, and cannot require referral from a primary care or other physician or health professional. Coverage is limited to a maximum of 20 visits each per benefit year. Plans may provide a combined chiropractic/acupuncture benefit with a minimum of 20 visits allowed for both disciplines.

(16) Biofeedback is an optional benefit which health plans may offer.

(17) Blood and Blood Products: Processing, storage, and administration of blood and blood products in inpatient and outpatient settings. Includes the collection and storage of autologous blood when medically indicated.

(18) Hospice: The hospice benefit is provided to subscribers who are diagnosed with a terminal illness with a life expectancy of twelve months or less and who elect hospice care for such illness instead of the traditional services by the plan.

The hospice benefit shall include nursing care, medical social services, home health aide services, physician services, drugs, medical supplies and appliances, counseling and bereavement services, physical therapy, occupational therapy, speech therapy, short-term inpatient care, pain control, and symptom management.

The hospice benefit may include, at the option of the health plan, homemaker services, services of volunteers, and short-term inpatient respite care.

Individuals who elect hospice care are not entitled to any other benefits under the plan for the terminal illness while the hospice election is in effect. The hospice election may be revoked at any time.

(19) Transplants: Coverage for organ transplants and bone marrow transplants which are not experimental or investigational. Includes reasonable medical and hospital expenses of a donor or an individual identified as a prospective donor if these expenses are directly related to the transplant for a subscriber.

Charges for testing of relatives for matching bone marrow transplants.

Charges associated with the search and testing of unrelated bone marrow donors through a recognized Donor Registry and charges associated with the procurement of donor organs through a recognized Donor Transplant Bank, if the expenses are directly related to the anticipated transplant of a subscriber.

(20) Reconstructive Surgery: Surgery to restore and achieve symmetry and surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following:

(A) Improve function

(B) Create a normal appearance to the extent possible. Includes reconstructive surgery to restore and achieve symmetry incident to mastectomy.

(21) Clinical Trial for Cancer Patients: Coverage for a subscriber's participation in a clinical trial when the subscriber has been diagnosed with cancer and has been accepted into a phase I through phase IV clinical trial for cancer, and the subscriber's treating physician recommends participation in the clinical trial after determining that participation will have a meaningful potential to benefit the subscriber. Coverage includes the payment of costs associated with the provision of routine patient care, including drugs, items, devices and services that would otherwise be covered if they were not provided in connection with an approved clinical

trial program; services required for the provision of the investigational drug, item, device or service; services required for the clinically appropriate monitoring of the investigational drug, item, device, or service; services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service; and services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including diagnosis or treatment of complications.

Exclusions: Provisions of non-FDA-approved drugs or devices that are the subject of the trial; services other than health care services, such as travel, housing, and other non-clinical expenses that a member may incur due to participation in the trial; any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient; services that are otherwise not a benefit (other than those excluded on the basis that they are investigational or experimental); and services that are customarily provided by the research sponsors free of charge for any enrollee in the trial. Coverage for clinical trials may be restricted to participating hospitals and physicians in California, unless the protocol for the trial is not provided in California.

(22) Phenylketonuria (PKU): Testing and treatment of PKU, including those formulas and special food products that are part of a diet prescribed by a licensed physician and managed by a health care professional in consultation with a physician who specializes in the treatment of metabolic disease, provided that the diet is deemed necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

(23) Participating health plans shall be responsible for identifying subscribers under the age of 21 who have conditions for which they may be eligible to receive services under the California Children's Services (CCS) Program and shall refer these individuals to the local CCS Program for determination of eligibility. If a subscriber is determined by the CCS Program to be eligible for CCS benefits, participating health plans shall provide primary care and services unrelated to the CCS eligible condition and shall ensure coordination of services between plan providers, CCS providers, and the local CCS Program.

(24) Participating health plans shall be responsible for identifying subscriber children who are severely emotionally disturbed and

shall refer these individuals to their county mental health department for continued treatment of the condition.

(b) This part shall not be construed to prohibit a plan's ability to impose cost-control mechanisms. Such mechanisms may include but are not limited to requiring prior authorization for benefits or providing benefits in alternative settings or using alternative methods.

(c) (1) The scope of benefits shall include all benefits which are covered under the California Children's Services (CCS) Program (Health and Safety Code Section 123800, et seq.), provided the subscriber meets the medical eligibility requirements of that program, as determined by that program.

(2) When a subscriber under the age of 21 is determined by the CCS Program to be eligible for benefits under that program, a participating health plan shall not be responsible for the provision of, or payment for, the particular services authorized by the CCS Program for the particular subscriber for the treatment of CCS eligible medical condition. All other services provided under the participating health plan shall be available to the subscriber.

(d) (1) The scope of benefits shall include benefits provided by a county mental health department to a subscriber child the department has determined is seriously emotionally disturbed or has a serious mental disorder pursuant to Section 5600.3 of the Welfare and Institutions Code.

(2) When a subscriber child is determined by a county mental health department to be seriously emotionally disturbed or to have a serious mental disorder pursuant to Section 5600.3 of the Welfare and Institutions Code, the participating health plan shall not be responsible for the provision of, or payment for, services provided by the county mental health department. This does not relieve the participating health plan from providing the mental health coverage specified in Section 2699.6700(a)(10).

(e) If, pursuant to any Workers' Compensation, Employer's Liability Law, or other legislation of similar purpose or import, benefits are provided or payable or payable to treat any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain, the participating health plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating health plan is reimbursed for such services.

(f) Coverage provided under the Healthy Families Program is secondary to all other coverage, except Medi-Cal. Benefits paid under this Program are determined after benefits have been paid as a result of a subscriber's enrollment in any other health care program. If medical services are eligible for reimbursement by insurance or covered under any other insurance or health care service plan, the participating health plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating health plan is reimbursed for such services.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.60, 12693.61, 12693.62 and 12693.755, Insurance Code.

2699.6703. Excluded Health Benefits.

(a) Health benefit plans offered under this program shall exclude all of the following:

(1) Any benefits specified as excluded within Section 2699.6700.

(2) Any benefits in excess of limits specified in Section 2699.6700.

(3) Services, supplies, items, procedures or equipment, which are not medically necessary as determined by the plan, unless otherwise specified in Section 2699.6700.

(4) Any benefits that are received prior to the subscriber's effective date of coverage. This exclusion does not apply to covered benefits to treat complications arising from services received prior to the subscriber's effective date of coverage.

(5) Any benefits that are received subsequent to the time the subscriber's coverage ends.

(6) Experimental or investigational services, including any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional medical standards, or for which the safety and efficiency have not been determined for use in the treatment of a particular illness, injury or medical condition for which the item or service in question is recommended or prescribed. This section

does not exclude clinical trials for cancer patients as provided pursuant to subsection 2699.6700(a)(21).

(7) Medical services that are received in an emergency care setting for conditions that are not emergencies if the subscriber reasonably should have known that an emergency care situation did not exist.

(8) Eyeglasses, except for those eyeglasses or contact lenses necessary after cataract surgery which are covered under Subsection 2699.6700(a)(3)(A).

(9) The diagnosis and treatment of infertility is not covered unless provided in conjunction with covered gynecological services. Treatments of medical conditions of the reproductive system are not excluded.

(10) Long-Term Care Benefits including long-term skilled nursing care in a licensed facility and respite care are excluded except as a participating health plan shall determine they are less costly, satisfactory alternatives to the basic minimum benefits. This section does not exclude short-term skilled nursing care or hospice benefits as provided pursuant to Subsection 2699.6700 (a)(13) and (a)(18).

(11) Cosmetic surgery that is solely performed to alter or reshape normal structures of the body in order to improve appearance.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.60 and 12693.755, Insurance Code.

2699.6705. Share of Cost for Health Benefits.

(a) Every participating health plan shall require copayments for benefits provided to subscribers, except as provided under federal law to subscribers who are American Indians receiving services at an Indian Health Service Facility, subject to the following:

(1) In any benefit year that the applicant has incurred $250 in health benefit copayments for services received by subscribers who live in one household and for whom the applicant applied to the program, the applicant shall be deemed to have met the copayment maximum.

(2) No deductibles shall be charged to subscribers for health benefits.

(3) The following specific copayments shall apply:

(A) Inpatient Facility Services provided in a licensed hospital, skilled nursing facility, hospice, or mental health facility: No copayment.

(B) Inpatient Professional Services provided in a licensed hospital, skilled nursing facility, hospice, or mental health facility: No copayment.

(C) Facility Services on an Outpatient Basis for Subscribers: No copayment, except for a $5 copayment per visit for Emergency Health Care Services. The emergency health care services copay is waived if the subscriber is hospitalized.

(D) Outpatient Professional Services: $5 copayment per office or home visit. No copayment for surgery or anesthesia; radiation, chemotherapy, or dialysis treatments.

(E) Outpatient Mental Health: $5 copayment per visit.

(F) Home Health Care: No copayment except for $5 per visit for physical, occupational, and speech therapy visits performed in the home.

(G) Alcohol and Drug Abuse Services: No copayment for inpatient services. $5 per visit for outpatient services.

(H) Hospice: No copayment for any services provided under this benefit.

(I) Transplants: No copayment for any services provided under this benefit.

(J) Physical, Occupational, and Speech Therapy: No copayment for therapy performed on an inpatient basis. $5 copayment per visit for therapy performed in the home or other outpatient setting.

(K) Biofeedback, Acupuncture, and Chiropractic Visits, when offered at the participating health plan’s option: $5 copayment per visit. For subscriber parents, copayment of $5 for each biofeedback visit for mental health.

(L) Diagnostic Laboratory Services, diagnostic and therapeutic radiological services, and other diagnostic services; durable

medical equipment, prosthetics and orthotics; blood and blood products; medical transportation services: No copayment.

(M) Prescription Drugs: No copayment for prescription drugs provided in an inpatient setting, or for drugs administered in the doctor's office or in an outpatient facility setting during the subscriber's stay at the facility. For subscriber children, no copayment for FDA approved contraceptive drugs.

$5 copayment per prescription for up to 30 day supply for brand name or generic drugs, including tobacco use cessation drugs. $5 copayment per 90 day supply of maintenance drugs purchased either through a participating health plan's participating pharmacies or through its mail order program. Maintenance drugs are drugs that are prescribed for 60 days or longer and are usually prescribed for chronic conditions such as arthritis, heart disease, diabetes, or hypertension.

For subscriber parents, $5 copayment for 90 day supply of FDA approved oral and injectable contraceptives and contraceptive devices. No refund if the medication is removed. (Represents the copayment for oral contraceptives at $5 copay for each 90-day supply for the approximate number of months the medication will be effective).

(4) Preventive services

(A) Periodic Health Exams; No copayment for subscriber children; $5 copayment per exam for subscriber parents.

(B) A variety of voluntary family planning services; including contraceptive services: No copayment for subscriber children. For subscriber parents $5 copayment per office visit and $5 copayment per device.

(C) Maternity Services: No copayment.

(D) Vision Services: No copayment for subscriber children. For subscriber parents, $5 copayment per visit.

Eye refraction to determine the need for corrective lenses. No copayment for subscriber children. For subscriber parents, optional with $5 copayment per exam and limited to one visit per year.

(E) Hearing Services and Hearing Aids: No copayment.

(F) Immunizations; No copayment for subscriber children. $5 copayment per visit for subscriber parent.

(G) Sexually Transmitted Disease Testing: No copayment for subscriber children. $5 copayment for subscriber parents.

(H) Cytology Examinations on a reasonable periodic basis: No copayment for subscriber children. For subscriber parents, $5 copayment per exam.

(I) Health Education Services: No copayment for subscriber children.

For subscriber parents, up to $5 copayment for diabetes outpatient self-management training, education, and medical nutrition therapy services. Charge may vary for other education services.

(J) Well Baby Care, Health Examinations and Other Office Visits for subscribers 24 months of age and under. No copayment.

(K) Gynecological Examinations and Cancer Screening: No copayment.

(5) No copayments shall apply if the applicant has submitted acceptable documentation as described in Subsection 2699.6600(c)(1)(GG) that the applicant or the subscriber is American Indian or Alaska Native.

(6) Reconstructive Surgery – No copayment

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code.
Reference: Sections 12693.21, 12693.615 and 12693.755, Insurance Code.

2699.6707. Annual or Lifetime Benefit Maximums.

There shall be no annual or lifetime financial benefit maximums in any of the coverage under the program.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21, 12693.60, 12693.615, Insurance Code.

2699.6709. Scope of Dental Benefits for Subscriber Children.

(a) The basic scope of benefits for subscriber children offered by a participating dental plan must comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975, including amendments as well as its applicable regulations, and shall include all of the benefits and services listed in this section, subject to the exclusions listed in Section 2699.6713.

The covered dental benefit is limited to the benefit level for the least costly dentally appropriate alternative. If a more costly, optional alternative is chosen by the applicant, the applicant will be responsible for all charges in excess of the covered dental benefit.

No other dental benefits shall be permitted to be offered by a participating dental plan as part of the program. The basic scope of dental benefits shall be as follows:

(1) Diagnostic and Preventive Benefits

(A) Initial and periodic oral examinations.

(B) Consultations, including specialist consultations.

(C) Roentgenology, limited as follows:

1. Bitewing x-rays in conjunction with periodic examinations are limited to one series of four films in any 6 consecutive month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.

2. Full mouth x-rays in conjunction with periodic examinations are limited to once every 24 consecutive months.

3. Panoramic film x-rays are limited to once every 24 consecutive months.

(D) Prophylaxis services, limited as follows: Not to exceed two in a twelve month period.

(E) Topical fluoride treatment.

(F) Dental sealant treatments, limited as follows: Permanent first and second molars only.

(G) Space maintainers, including removable acrylic and fixed band type.

(H) Preventive dental education and oral hygiene instruction.

(2) Restorative Dentistry

(A) Restorations, limited as follows:

1. Amalgam, composite resin, acrylic, synthetic or plastic restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is considered optional.

2. Composite resin or acrylic restorations in posterior teeth are optional.

3. Micro filled resin restorations which are non-cosmetic.

4. Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary.

(B) Use of pins and pin build-up in conjunction with a restoration.

(C) Sedative base and sedative fillings.

(3) Oral Surgery

(A) Extractions, including surgical extractions

(B) Removal of impacted teeth, limited as follows: Surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.

(C) Biopsy of oral tissues

(D) Alveolectomies

(E) Excision of cysts and neoplasms

(F) Treatment of palatal torus

(G) Treatment of mandibular torus

(H) Frenectomy

(I) Incision and drainage of abscesses

(J) Post-operative services including exams, suture removal and treatment of complications

(K) Root recovery (separate procedure)

(4) Endodontics

(A) Direct pulp capping

(B) Pulpotomy and vital pulpotomy

(C) Apexification filling with calcium hydroxide

(D) Root amputation

(E) Root canal therapy, including culture canal, and retreatment of previous root canal therapy limited as follows: Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present, and/or the patient is experiencing symptoms. Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.

(F) Apicoectomy

(G) Vitality tests

(5) Periodontics

(A) Emergency treatment, including treatment for periodontal abscess and acute periodontitis.

(B) Periodontal scaling and root planing, and subgingival curettage, limited as follows: Five quadrant treatments in any 12 consecutive months.

(C) Gingivectomy

(D) Osseous or muco-gingival surgery

(6) Crowns and Fixed Bridges

(A) Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three quarter crown, and stainless steel. Related dowel pins and pin build-up are also included. Crowns are limited as follows:

1. Replacement of each unit is limited to once every 36 consecutive months, except when the crown is no longer functional as determined by the dental plan.

2. Only acrylic crowns and stainless steel crowns are a benefit for children under 12 years of age. If other types of crowns are chosen as an optional benefit for children under 12 years of age, the covered dental benefit level will be that of an acrylic crown.

3. Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.

4. Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.

(B) Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold, are limited as follows:

1. Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.

2. A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person 16 years of age or older and the patient’s oral health and general dental condition permits. Under the age of 16, it is considered optional dental treatment. If performed on a subscriber under the age of 16, the applicant must pay the difference in cost between the fixed bridge and a space maintainer.

3. Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.

4. Fixed bridges are optional when provided in connection with a partial denture on the same arch.

5. Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.

(C) The program allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction which is optional treatment.

(D) Recementation of crowns, bridges, inlays and onlays.

(E) Cast post and core, including cast retention under crowns.

(F) Repair or replacement of crowns, abutments or pontics.

(7) Removable Prosthetics

(A) Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers, limited as follows:

1. Partial dentures are not to be replaced within 36 consecutive months, unless:

a. It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or

b. The denture is unsatisfactory and cannot be made satisfactory.

2. The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges.

3. A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.

4. Full upper and/or lower dentures are not to be replaced within 36 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair.

5. The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the applicant will be responsible for all additional charges.

(B) Office or laboratory relines or rebases, limited as follows: One per arch in any 12 consecutive months.

(C) Denture repair.

(D) Denture adjustment.

(E) Tissue conditioning, limited to two per denture.

(F) Denture duplication.

(G) Implants are considered an optional benefit.

(H) Stayplates, limited as follows: Stayplates are a benefit only when used as anterior space maintainers for children.

(8) Orthodontic Treatment, limited as follows: If the subscriber child meets the eligibility requirements for medically necessary orthodontia coverage under the California Children's Services program, benefits shall be provided and determined by the California Children's Services program.

(9) Other Dental Benefits

(A) Local anesthetics.

(B) Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure.

(C) Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of their licensure.

(D) Emergency treatment, palliative treatment.

(E) Coordination of benefits with subscriber's health plan in the event hospitalization or outpatient surgery setting is medically appropriate for dental services.

(10) This part shall not be construed to prohibit a dental plan's ability to impose cost control mechanisms. Such mechanisms may include but are not limited to requiring prior authorization for benefits or providing alternative treatments or services.

(11) Participating dental plans shall be responsible for identifying subscribers who have conditions for which they may be eligible to receive services under the California Children's Services (CCS) Program and shall refer these individuals to the local CCS Program for determination of eligibility. If a subscriber is determined by the CCS Program to be eligible for CCS benefits, participating dental plans shall provide primary care and services unrelated to the CCS eligible condition and shall ensure coordination of services between plan providers, CCS providers, and the local CCS program.

(b) (1) The scope of dental benefits shall also include all dental benefits which are covered under the California Children's Services program (Health and Safety Code Section 123800 et seq.), provided the subscriber meets the medical eligibility requirements of that program, as determined by that program.

(2) When a subscriber is determined by the California Children's Services Program (Health and Safety Code Section 123800 et seq.) to be eligible for benefits under that program, a participating dental plan shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services Program for the particular subscriber for the treatment of a California Children's Services Program eligible medical condition. All other services provided under the participating dental plan shall be available to the subscriber.

(c) If, pursuant to any Workers' Compensation, Employer's Liability Law, or other legislation of similar purpose or import, a third party is responsible for all or part of the cost of dental services to treat any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain, the participating dental plan shall provide the services at the time of need, and the subscriber or

applicant shall cooperate to assure that the participating dental plan is reimbursed for such services.

(d) Coverage provided under the Healthy Families Program is secondary to all other coverage, except Denti-Cal. Benefits paid under this Program are determined after benefits have been paid as a result of a subscriber's enrollment in any other dental care program. If dental services are eligible for reimbursement by insurance or covered under any other insurance or dental care service plan, the participating dental plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating dental plan is reimbursed for such services.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.63 and 12693.64, Insurance Code.

2699.6711. Scope of Dental Benefits for Subscriber Parents.

(a) The basic scope of benefits for subscriber parents offered by a participating dental plan must comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975, including amendments as well as its applicable regulations, and shall include all of the benefits and services listed in this section, subject to certain exclusions as listed in Section 2699.6713.

The covered dental benefit is limited to the benefit level for the least costly dentally appropriate alternative. If a more costly, optional alternative is chosen by the applicant, the applicant will be responsible for all charges in excess of the covered dental benefits.

No other dental benefits shall be permitted to be offered by a participating dental plan as part of the program. The basic scope of dental benefits shall be as follows:

(1) Diagnosis and Preventive Benefits

(A) Initial and periodic oral examinations – oral examinations are benefits only twice in a benefit year.

(B) Consultations, including specialist consultations

(C) Roentgenology, limited as follows:

1. Bitewing x-rays in conjunction with periodic examinations are limited to one series of four films in a benefit year.

2. Full mouth x-rays in conjunction with periodic examinations are limited to once in a three-year period unless special need is shown.

3. Panoramic film x-rays are limited to once in a three year period.

(D) Prophylaxis Services, not to exceed two in a twelve month period.

A third cleaning will be provided as a benefit for high-risk patients in the following categories:

1. Women who are pregnant

2. Subscribers undergoing cancer chemotherapy

3. Subscribers with compromising systemic diseases such as diabetes as determined to be medically necessary for appropriate dental care by the provider and approved by the plan.

(E) Space maintainers, including removable acrylic and fixed band type.

(F) Preventive dental education and oral hygiene instructions

(2) Restorative Dentistry

(A) Restorations, limited as follows:

1. Amalgam, composite resin, acrylic, synthetic or plastic restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is considered optional.

2. Composite resin or acrylic restorations in posterior teeth are optional.

3. Micro filled resin restorations which are non-cosmetic.

4. Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary.

(B) Use of pins and pin build-up in conjunction with a restoration.

(C) Sedative base and sedative fillings.

(3) Oral Surgery

(A) Extractions, including surgical extractions.

(B) Removal of impacted teeth. Surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.

(C) Biopsy of oral tissues

(D) Alveolectomies

(E) Excision of cysts and neoplasms

(F) Treatment of palatal torus

(G) Treatment of mandibular torus

(H) Frenectomy

(I) Incision and drainage of abscesses

(J) Post-operative services including exams, suture removal and treatment of complications.

(K) Root recovery (separate procedure)

(4) Endodontics

(A) Direct pulp capping

(B) Pulpotomy and vital pulpotomy

(C) Apexification filling with calcium hydroxide

(D) Root amputation

(E) Root canal therapy, including culture canal, and retreatment of previous root canal therapy limited as follows.

Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present, and/or the patient is experiencing symptoms. Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology is not a covered benefit.

(F) Apicoectomy

(G) Vitality tests

(5) Periodontics

(A) Emergency treatment, including treatment for periodontal abscess and acute periodontitis.

(B) Periodontal scaling and root planing, and subgingival curettage, limited as follows: Five quadrant treatments in any 12 consecutive months.

(C) Gingevectomy

(D) Osseous or Muco-Gingival Surgery.

(E) Periodontal procedures which include cleanings are subject to the limitations described in Subsection 2699.6711(a)(1)(D).

(6) Crown, Jackets, Cast and Fixed Bridges

(A) Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three-quarter crown, and stainless steel. Related dowel pins and pin build-up are also included. Crowns are limited as follows:

1. Replacement of each unit is limited to once every five years.

2. Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either

fractured or decayed to the extent that they will not hold a filling.

3. Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.

(B) Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold, are limited as follows:

1. Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.

2. A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth and the patient's oral health and general dental condition permits.

3. Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.

4. Fixed bridges are optional when provided in connection with a partial denture on the same arch.

5. Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.

(C) The program allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction which is an optional treatment.

(D) Recementation of crowns, bridges, inlays and onlays.

(E) Cast post and core, including cast retention under crowns.

(F) Repair or replacement of crowns, abutments or pontics.

(7) Removable Prosthetics

(A) Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers, limited as follows:

1. Partial dentures are not to be replaced within five years unless:

   a. It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, there has been such an extensive loss of remaining teeth, or a change in supporting tissues, or

   b. The denture is unsatisfactory and cannot be made satisfactory.

2. The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges.

3. A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.

4. Full upper and/or lower dentures are not to be replaced within five years unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair, the plan determines that there has been such an extensive loss of remaining teeth, or a change in supporting tissue that the existing appliance cannot be made satisfactory.

5. The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. The plan will pay the applicable percentage of the dentist's fee for a standard partial or complete denture up to a maximum fee allowance (or established UCR fee). If a more personalized or specialized treatment is chosen by the patient and the dentist, the applicant will be responsible for all additional charges.

(B) Office or laboratory relines or rebases, limited to one per arch in any 12 consecutive months.

(C) Denture repair

(D) Denture adjustment

(E) Tissue conditioning, limited to two per denture

(F) Denture duplication

(G) Implants (appliances inserted into bone or soft tissue in the jaw usually to anchor a denture) are covered.

(H) Stayplates – provided as a benefit only when used to replace extracted anterior teeth for adults during a healing period.

(8) Other Dental Benefits

(A) Local anesthetics

(B) Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure.

(C) Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of their licensure.

(D) Emergency treatment, palliative treatment.

(E) Coordination of benefits with subscriber's health plan in the event hospitalization or outpatient surgery setting is medically appropriate for dental services.

(9) This part shall not be construed to prohibit a dental plan's ability to impose cost control mechanisms. Such mechanisms may include but are not limited to requiring prior authorization for benefits or providing alternative treatments or services.

(10) Participating dental plans shall be responsible for identifying subscribers under the age of 21 who have conditions for which they may be eligible to receive services under the California Children's Services (CCS) Program and shall refer these individuals to the local CCS Program for determination of eligibility. If a subscriber is determined by the CCS Program to be eligible for CCS benefits, participating dental plans shall provide primary care and services unrelated to the CCS eligible condition and shall ensure coordination of services between plan providers, CCS providers, and the local CCS program.

(b) (1) The scope of dental benefits shall also include all dental benefits which are covered under the California Children's Services program (Health and Safety Code Section 123800 et seq.), provided the subscriber meets the medical eligibility requirements of that program, as determined by that program.

(2) When a subscriber under the age of 21 is determined by the California Children's Services Program (Health and Safety Code Section 123800 et seq.) to be eligible for benefits under that program, a participating dental plan shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services Program for the particular subscriber for the treatment of a California Children's Services Program eligible medical condition. All other services provided under the participating dental plan shall be available to the subscriber.

(c) If, pursuant to any Workers' Compensation, Employer's Liability Law, or other legislation of similar purpose or import, a third party is responsible for all or part of the cost of dental services to treat any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain, the participating dental plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating dental plan is reimbursed for such services.

(d) Coverage provided under the Healthy Families Program is secondary to all other coverage, except Denti-Cal. Benefits paid under this Program are determined after benefits have been paid as a result of a subscriber's enrollment in any other dental care program. If dental services are eligible for reimbursement by insurance or covered under any other insurance or dental care service plan, the participating dental plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating dental plan is reimbursed for such services.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code.
Reference: Sections 12693.21, 12693.63, 12693.64 and 12693.755, Insurance Code

2699.6713. Excluded Dental Benefits for All Subscribers.

(a) A dental benefits plan offered under this program shall exclude:

(1) Any benefits specified as excluded within Section 2699.6709 or Section 2699.6711.

(2) Any benefits in excess of limits specified in Section 2699.6709 or Section 2699.6711.

(3) Services, supplies, items, procedures or equipment, which are not medically necessary as determined by the plan, unless otherwise specified in Section 2699.6709 or Section 2699.6711.

(4) Any benefits received or costs that were incurred in connection with any dental procedures started prior to the subscriber's effective date of coverage. This exclusion does not apply to covered services to treat complications arising from services received prior to the subscriber’s effective date of coverage.

(5) Any benefits that are received subsequent to the time the subscriber’s coverage ends.

(6) Experimental or investigational services, including any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional medical standards, or for which the safety and efficiency have not been determined for use in the treatment of a particular illness, injury or medical condition for which the item or service in question is recommended or prescribed.

(7) Dental services that are received in an emergency care setting for conditions that are not emergencies if the subscriber reasonably should have known that an emergency care situation did not exist.

(8) Procedures, appliances, or restorations to correct congenital or developmental malformations are not covered benefits unless specifically listed in Section 2699.6709 or Section 2699.6711.

(9) Cosmetic dental care.

(10) General anesthesia or intravenous/conscious sedation unless specifically listed as a benefit or is given by a dentist for covered oral surgery.

(11) Hospital charges of any kind.

(12) Major surgery for fractures and dislocations.

(13) Loss or theft of dentures or bridgework.

(14) Malignancies.

(15) Dispensing of drugs not normally supplied in a dental office.

(16) Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist's office due to the general health and physical limitations of the subscriber.

(17) The cost of precious metals used in any form of dental benefits.

(18) The surgical removal of implants.

(19) Services of a pedodontist/pediatric dentist for subscriber children except when a subscriber child is unable to be treated by his or her panel provider or treatment by a pedodontist/pediatric dentist is medically necessary, or his or her panel provider is a pedodontist/pediatric dentist.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.63 and 12693.755, Insurance Code.

2699.6715. Share of Cost for Dental Benefits for Subscriber Children.

(a) Every participating dental health plan shall require copayments for the dental benefits listed in Subsection 2699.6709 (a) of these regulations provided to subscribers subject to the following:

(1) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(1), "Diagnostic and Preventive Benefits."

(2) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(2), "Restorative Dentistry."

(3) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(3), "Oral Surgery", with the following exceptions:

(A) Removal of impacted teeth is subject to a copayment per tooth as follows:

1. Soft tissue impaction -- No copayment.

2. Bony impaction -- $5 copayment per tooth.

(B) Root recovery -- $5 per root.

(4) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(4), “Endodontics”, with the following exceptions:

(A) Root canal therapy -- $5 per canal. $5.00 copayment per canal for retreatment of previous root canal.

(B) An apicoectomy performed in conjunction with root canal therapy is subject to a copayment of $5 per canal. When performed as a separate procedure, an apicoectomy is subject to a copayment of $5 per canal.

(5) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(5), “Periodontics”, with the following exceptions:

(A) Osseous or muco-gingival surgery -- $5 per quadrant.

(B) Gingivectomy -- no copayment.

(6) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(6), “Crowns and Fixed Bridges” with the following exceptions:

(A) Porcelain crowns; porcelain fused to metal crowns; full metal crowns; and gold onlays or 3/4 crowns; are each subject to a copayment of $5.

(B) Pontics are each subject to a copayment of $5.

(7) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(7), “Removable Prosthetics”, with the following exceptions:

(A) Dentures are subject to copayments as follows:

1. Complete maxillary denture --$5.

2. Complete mandibular denture -- $5.

3. Partial acrylic upper or lower denture with clasps--$5.

4. Partial upper or lower denture with chrome cobalt alloy lingual or palatal bar, clasps and acrylic saddles --$5.

5. Removable unilateral partial denture -- $5.

(B) Reline for an upper, lower or partial denture is subject to a copayment per unit as follows:

1. Office reline -- No copayment.

2. Laboratory reline --$5.

(C) Denture duplication-- $5.

(8) No copayments shall be charged for benefits listed under Subsection 2699.6709(c)(8), “Orthodontia.”

(9) No copayments shall be charged for benefits listed under Subsection 2699.6709(a)(9), “Other”.

(10) The copayment for any precious (noble) metals used in any crown or bridge will be the full cost of the actual precious metal used.

(11) Notwithstanding any other provision in this section, an alternative copayment shall apply under the following circumstances: For children under six years of age, who are unable to be treated by their panel provider, and who have been referred to a pedodontist/pediatric dentist, the copayment is $5.

(b) A fee of $5 shall be charged for failure to cancel an appointment without 24 hours prior notification.

(c) No deductibles shall be charged to subscriber children for dental benefits.

(d) No copayments or fees shall apply if the applicant has submitted acceptable documentation as described in Subsection 2699.6600(c)(1)(GG) that the applicant or subscriber is American Indian or Alaska Native.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21, 12693.63, Insurance Code.

2699.6717. Share of Cost for Dental Benefits for Subscriber Parents.

(a) Every participating dental plan shall require copayments for the dental benefits provided to subscriber parents subject to the following:

(1) No copayments shall be charged for benefits listed under Subsection 2699.6711(a)(1), “Diagnostic and Preventive.”

(2) No copayments shall be charged for benefits listed under Subsection 2699.6711(a)(2), “Restorative Dentistry”, with the following exceptions:

(A) Micro filled resin restorations (non-cosmetic, acid etched, bonded, light cured):

1. $40 per surface

2. $65 for two or more surfaces

(3) No copayments shall be charged for benefits listed under subsection 2699.6711(a)(3), “Oral Surgery”, with the following exceptions:

(A) Removal of impacted teeth is subject to a copayment per tooth as follows:

1. Partially bony impaction -- $15 copayment.

2. Complete bony impaction -- $15 copayment.

(B) Root recovery as a separate procedure -- $5 per root.

(4) No copayments shall be charged for benefits listed under Subsection 2699.6711(a)(4), “Endodontics” with the following exceptions:

(A) Root canal therapy or retreatment of previous root canal therapy (excluding restoration) is subject to copayments as follows:

1. 1 canal - $20

2. 2 canals - $40

3. 3 canals - $60

4. 4 canals - $80

(B) An apicoectomy performed in conjunction with filling or root canal therapy at the same time is subject to a copayment of $60 per canal. When performed as a separate procedure, an apicoectomy is subject to a copayment of $50 per canal.

(5) No copayments shall be charged for benefits listed under subsection 2699.6711(a)(5), “Periodontics”, with the following exceptions:

(A) Osseous or muco-gingival surgery is subject to a copayment of $150 per quadrant (includes post surgical visits).

(B) Gingivectomy is subject to a $5 copayment per tooth (fewer than six teeth).

(6) No copayments shall be charged for benefits listed under subsection 2699.6711(a)(6), “Crowns and Bridges” (per unit), with the following exceptions:

(A) Porcelain crowns; porcelain fused to metal crowns (excluding molars) full crowns, or 3/4 crowns; are each subject to a copayment of $50. Cast post and core are subject to $40 per unit copayment, and bonded Maryland Bridge is subject to $50 copayment per unit.

(B) Pontics are each subject to a copayment of $50.

(7) “Removable Prosthetics” as listed under Subsection 2699.6711(a)(7) are subject to the following copayments:

(A) Dentures are subject to copayments as follows:

1. Complete upper denture (3 adjustments within 60 days) - $65.

2. Complete lower denture (3 adjustments within 60 days) - $65.

3. Partial acrylic upper or lower denture with clasps - $5.

4. Partial acrylic upper or lower denture with 2 chrome cobalt allow clasps is subject to a base fee of $65.

5. Partial lower or upper denture with chrome cobalt allow, lingual or palatal bar, clasps and acrylic saddles - $65 base fee (included two clasps).

6. Removable unilateral partial denture - $50.

7. Stayplate (maximum two teeth included) - $60.

(B) Reline for an upper, lower or partial denture is subject to a copayment per unit as follows:

1. Office reline – No copayment.

2. Laboratory reline - $15 copayment.

(C) Denture duplication -- $20 copayment.

(D) Denture Repairs

1. Adding teeth to partial denture to replace natural tooth:

First tooth - $10 copayment.

Each additional tooth - $5 copayment.

2. Broken partial denture (no teeth involved)

Replacement broken clasp - $5 copayment.

3. Add clasp with rest - $5 copayment.

(8) Other Services

After hour visit - $35 copayment.

Broken appointment - $5 copayment.

(9) Implants – If implants are utilized, the plan will apply the cost of a standard full or partial denture towards the cost of implants and appliances constructed thereon, and if performed, subscriber parent must pay the difference plus any applicable copayment. Surgical removal of implants is not covered.

(b) No deductibles shall be charged to subscriber parents for dental benefits.

(c) No copayments or fees shall apply if the applicant has submitted acceptable documentation as described in Subsection 2699.6600(c)(1)(GG) that the applicant or subscriber is American Indian or Alaska Native.

(d) Note: Any procedure not listed in the EOC is available on a fee-for service basis.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code.
Reference: Sections 12693.21, 12693.63 and 12693.755, Insurance Code.

2699.6719 Waiting Periods for Receipt of Specified Benefits.

Participating dental plans may not subject enrollees to waiting periods for receipt of specified benefits.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21, 12693.63, Insurance Code.

2699.6721. Scope of Vision Benefits.

(a) The basic scope of benefits offered by a participating vision plan must comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975, including amendments as well as its applicable regulations, and shall include all of the benefits and services listed in this section, subject to the exclusions listed in Section 2699.6723. No other vision benefits shall be permitted to be offered by a participating vision plan as part of the program. The basic scope of vision benefits shall be as follows:

(1) Examinations: Each subscriber shall be entitled to a comprehensive vision examination, including a complete analysis of the eyes and related structures, as appropriate, to determine the presence of vision problems or other abnormalities as follows:

(A) Case history: Review of subscriber's main reason for the visit, past history, medications, general health, ocular symptoms, and family history.

(B) Evaluation of the health status of the visual system; including:

1. External and internal examination, including direct and/or indirect ophthalmoscopy;

2. Assessment of neurological integrity, including that of pupillary reflexes and extraocular muscles;

3. Biomicroscopy of the anterior segment of the eye, including observation of the cornea, lens, iris, conjunctiva, lids and lashes;

4. Screening of gross visual fields; and

5. Pressure testing through tonometry.

(C) Evaluation of refractive status, including:

1. Evaluation for visual acuity;

2. Evaluation of subjective, refractive, and accommodative function; and

3. Objective testing of a patient's prescription through retinoscopy.

(D) Binocular function test.

(E) Diagnosis and treatment plan, if needed.

(F) Examinations are limited to once each twelve month benefit period, beginning July first of each year.

(2) When the vision examination indicates that corrective lenses are necessary, each subscriber is entitled to necessary frames and lenses, including coverage for single vision, bifocal, trifocal, lenticular, tinted, photochromic, and polycarbonate lenses as appropriate.

Frames and lenses are limited to once each twelve month benefit period, beginning July first of each year.

(3) Contact lenses shall be covered as follows:

(A) Necessary contact lenses shall be covered in full upon prior authorization from the vision plan, for certain conditions. These conditions may include the following:

1. Following cataract surgery;

2. To correct extreme visual acuity problems that cannot be corrected with spectacle lenses;

3. Certain conditions of Anisometropia; and

4. Keratoconus.

(B) Elective contact lenses may be chosen instead of corrective lenses and a frame at a maximum benefit allowance of $110, which includes examinations, fittings and lenses.

(C) Contact lenses are limited to once each twelve month benefit period, beginning July first of each year.

(4) A low vision benefit shall be provided to subscribers who have severe visual problems that are not correctable with regular lenses. This benefit requires prior approval from the participating vision plan. With this prior approval, supplementary testing and supplemental care, including low vision therapy as visually necessary or appropriate, shall be provided.

For subscriber parents, the covered person is required to pay a $5 copayment for any approved Low Vision services.

(5) Participating vision plans shall be responsible for identifying subscribers under the age of 21 who have conditions for which they may be eligible to receive services under the California Children's Services (CCS) Program and shall refer these individuals to the local CCS program for determination of eligibility. If a subscriber is determined by the CCS Program to be eligible for CCS benefits, participating vision plans shall provide services unrelated to the CCS eligible condition and shall ensure coordination of services between plan providers, CCS providers, and the local CCS program.

(b) (1) The scope of vision benefits shall also include all vision benefits which are covered under the California Children's Services Program (Health and Safety Code Section 123800 et seq.), provided the subscriber meets the medical eligibility requirements of that program, as determined by that program.

(2) When a subscriber under the age of 21 is determined by the California Children's Services Program to be eligible for vision benefits under that program, a participating vision plan shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services Program for the particular subscriber for the treatment of a California Children's Services Program eligible medical condition. All other services provided under the participating vision plan shall be available to the subscriber.

(c) If, pursuant to any Workers' Compensation, Employer's Liability Law, or other legislation of similar purpose or import, a third party is responsible for all or part of the cost of vision services to treat any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain, the participating vision plan

shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating vision plan is reimbursed for such services.

(d) Coverage provided under the Healthy Families Program is secondary to all other coverage, except Medi-Cal. Benefits paid under this Program are determined after benefits have been paid as a result of a subscriber's enrollment in any other vision care program. If vision services are eligible for reimbursement by insurance or covered under any other insurance or vision care service plan, the participating vision plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating vision plan is reimbursed for such services.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.65, 12693.66 and 12693.755, Insurance Code.

2699.6723. Excluded Vision Benefits.

(a) A vision benefits plan offered under this program shall exclude:

(1) Any benefits specified as excluded within Section 2699.6721.

(2) Any benefits in excess of limits specified in Section 2699.6721.

(3) Services, supplies, items, procedures or equipment, which are not medically necessary as determined by the plan, unless otherwise specified in Section 2699.6721.

(4) Any benefits that were received prior to the subscriber's effective date of coverage.

(5) Any benefits that were received subsequent to the time the subscriber's coverage ends.

(6) Benefits that are not obtained in compliance with the rules and policies of the subscriber's vision plan.

(7) Orthopics or vision training and any associated supplemental testing.

(8) Aniseikonic lenses.

(9) Plano lenses.

(10) Two pairs of glasses in lieu of bifocals, unless medically necessary and with the prior authorization of the vision plan.

(11) Replacement or repair of lost or broken lenses or frames.

(12) Medical or surgical treatment of the eyes.

(13) Eye examinations required as a condition of employment.

(14) Any additional costs over and above the plan's frame allowance, as specified in subsections 2699.6725(a)(2) and 2699.6725(b)(2).

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.65 and 12693.755, Insurance Code.

2699.6725. Share of Cost for Vision Benefits.

(a) A participating vision plan shall require copayments for benefits provided to subscribers utilizing the services of the vision plan's panel of approved providers subject to the following:

(1) Examinations: $5 copayment per examination.

(2) Frames and lenses: $5 copayment, for frames with lenses, or for frames or lenses when purchased separately. No additional copayment for tinted, photochromic, or polycarbonate lenses.

A frame allowance of $75 is provided by the vision plan. The subscriber is responsible for any costs exceeding this allowance.

The following options are considered cosmetic and any costs associated with the selection of these options will be the financial responsibility of the applicant.

(A) Blended lenses (bifocals which do not have a visible dividing line).

(B) Contact lenses except as specified in Section 2699.6721(a)(3).

(C) Oversized lenses (larger than standard lens blank to accommodate prescriptions).

(D) Progressive multifocal lenses.

(E) Coated or laminated lenses.

(F) UV protected lenses.

(G) Other optional cosmetic processes.

(H) A frame that costs more than the plan's allowance.

(3) Necessary contact lenses, as defined in Subsection 2699.6721(a)(3): No copayment.

(4) Elective contact lenses: an allowance of $110 will be provided by the vision plan toward the cost of an examination, contact lens evaluation, fitting costs and materials. This allowance will be in lieu of all benefits including examination and material costs. The subscriber is responsible for any costs exceeding this allowance.

(5) Low vision benefits:

(A) Supplementary testing: No copayment; and

(B) Supplemental care: $5 copayment.

(b) Services from providers not included in the vision plan's panel of approved providers:

When a subscriber obtains services from a provider not included in the vision plan's panel of approved providers, the applicant will be responsible for paying the provider for all services and materials received at the time of their appointment. The participating vision plan will reimburse the applicant within fourteen (14) calendar days after receipt of the paid itemized bill or statement, according to the schedule of allowances as follows:

(1) Professional fees:

(A) Vision exams - up to $35.00

(2) Materials:

(A) Each single vision lens - up to $12.50 or a pair of single vision lenses up to $25.00.

(B) Each bifocal lens - up to $20.00 or a pair of bifocal lenses up to $40.00.

(C) Each trifocal lens - up to $25.00 or a pair of trifocal lenses up to $50.00.

(D) Each lenticular lens - up to $50.00 or a pair of lenticular lenses up to $100.00.

(E) Frame - up to $40.00.

(F) Tinted or photochromic lenses - up to $5.00.

(G) Polycarbonate lenses - up to $10.00.

(H) Each pair of necessary contact lenses - up to $250.00.

(I) Each pair of elective contact lenses - up to $110.00. Determination of whether contact lenses are necessary or elective when obtained from providers not included in the vision plan's panel of approved providers will be the responsibility of the vision plan. Reimbursement for elective contact lenses is in lieu of all benefits, including examination and materials.

(3) Low vision benefits: Low vision benefits obtained from a provider not included in the vision plan's panel of approved providers will be reimbursed in accordance with what the participating vision plan would pay a provider included in the vision plan's panel of approved providers for this benefit.

(c) No deductibles shall be charged to subscribers for vision benefits.

(d) For subscriber parents who receive vision services from one of the participating member doctors, covered services as described are provided with no additional out-of-pocket costs after an applicable copayment. Additional services selected for cosmetic purposes are the financial responsibility of the patient.

(e) No copayments shall apply if the applicant has submitted acceptable documentation as described in Section 2699.6600(c)(1)(GG) that the applicant or the subscriber is American Indian or Alaska Native. However, there is no limitation on the payments required under Subsection (b) above.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.65 and 12693.755, Insurance Code.

ARTICLE 4. RISK CATEGORIES AND FAMILY CONTRIBUTIONS

2699.6800. Risk Categories Dental and Vision.

(a) Subscriber child rates are as follows:

(1) Dental and vision benefits plan rates shall be based exclusively on one risk category: geographic region of the subscriber's residence. The six geographic regions for subscribers residing within the State of California shall be as follows unless they are altered pursuant to (2) below:

(A) Area 1 shall include the counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yuba, and Yolo.

(B) Area 2 shall include the counties of Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus.

(C) Area 3 shall include the counties of Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara.

(D) Area 4 shall include the counties of Orange, Santa Barbara, and Ventura.

(E) Area 5 shall include the county of Los Angeles.

(F) Area 6 shall include the counties of Riverside, San Bernardino, and San Diego.

(2) The Board may allow one or more dental and vision plans to subdivide one or more geographic regions. The Board shall determine which region or regions may be subdivided and the number of subregions into which a region will be divided. No subregion shall be smaller than one county. Plans rates may differ between subregions.

(3) Dental and Vision plan rates shall be paid on a per capita basis and the per capita rate shall not be differentiated on the basis of age or number of subscribers covered by one family contribution.

(b) Subscriber parent rates are as follows:

(1) Dental and vision benefits plan rates shall be based exclusively on one risk category: geographic region of the subscriber's residence. The six geographic regions for subscribers residing within the State of California shall be as follows unless they are altered pursuant to (2) below:

(A) Area 1 shall include the counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yuba, and Yolo.

(B) Area 2 shall include the counties of Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus.

(C) Area 3 shall include the counties of Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara.

(D) Area 4 shall include the counties of Orange, Santa Barbara, and Ventura.

(E) Area 5 shall include the county of Los Angeles.

(F) Area 6 shall include the counties of Riverside, San Bernardino, and San Diego.

(2) The Board may allow one or more dental and vision plans to subdivide one or more geographic regions. The Board shall determine which region or regions may be subdivided and the number of subregions into which a region will be divided. No subregion shall be smaller than one county. Plans rates may differ between subregions.

(3) Dental and Vision plan rates shall be paid on a per capita basis and the per capita rate shall not be differentiated on the basis of age or number of subscribers covered by one family contribution.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.34, 12693.615 and 12693.755, Insurance Code.

2699.6801. Risk Categories Health.

(a) Subscriber child rates are as follows:

(1) With the exception of rates applicable to AIM infants in the first two calendar months of life, health benefit plan rates shall be based on two risk categories; geographic region of the subscriber's residence and the age of the subscriber. Health plan benefit rates for subscribers entering the program as AIM infants shall initially be determined in accordance with subsection (c).

(2) The age categories for subscriber children shall be as follows:

(A) The first age category is subscribers under the age of one.

(B) The second age category is subscribers of the age of one and over.

(3) The six geographic regions for subscribers residing within the State of California shall be as follows unless they are altered pursuant to (4) below:

(A) Area 1 shall include the counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yuba, and Yolo.

(B) Area 2 shall include the counties of Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus.

(C) Area 3 shall include the counties of Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara**.**

(D) Area 4 shall include the counties of Orange, Santa Barbara, and Ventura.

(E) Area 5 shall include the county of Los Angeles.

(F) Area 6 shall include the counties of Riverside, San Bernardino, and San Diego.

(4) The Board may allow one or more health plans to subdivide one or more geographic regions. The Board shall determine which region or regions may be subdivided and the number of subregions into which a region will be divided. No subregion shall be smaller than one county. Plans rates may differ between subregions.

(5) Health plan rates shall be paid on a per capita basis and the per capita rate shall not be differentiated on the basis of the number of subscribers covered by one family contribution.

(b) Subscriber parent rates are as follows:

(1) Health benefit plan rates shall be based on two risk categories; geographic region of the subscriber's residence and age of the subscriber parent.

(2) The age categories for subscriber parents shall be as follows:

(A) The first age category is subscribers under the age of forty-five.

(B) The second age category is subscribers age forty-five and over.

(3) Health plans shall also be paid an additional lump sum payment for each delivery of one or more newborns to a subscriber parent while enrolled in the program.

(4) The six geographic regions for subscribers residing within the State of California shall be as follows unless they are altered pursuant to (5) below:

(A) Area 1 shall include the counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yuba, and Yolo.

(B) Area 2 shall include the counties of Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, and Stanislaus.

(C) Area 3 shall include the counties of Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara.

(D) Area 4 shall include the counties of Orange, Santa Barbara, and Ventura.

(E) Area 5 shall include the county of Los Angeles.

(F) Area 6 shall include the counties of Riverside, San Bernardino, and San Diego.

(5) The Board may allow one or more health plans to subdivide one or more geographic regions. The Board shall determine which region or regions may be subdivided and the number of subregions into which a region will be divided. No subregion shall be smaller than one county. Plans rates may differ between subregions.

(6) Health plan rates shall be paid on a per capita basis and the per capita rate shall not be differentiated on the basis of number of subscribers covered by one family contribution.

(c) Subscriber Rates for AIM Infants

(1) The initial rate for subscribers entering the program as AIM infants shall be determined as follows:

(A) The rate shall be available only to health plans participating as contractors in the AIM Program and shall cover a health plan's entire service area.

(B) The rate shall cover the birth month through the end of the AIM infant's second month of life. After this period, a health plan shall be paid rates in accordance with the age and geographic region categories in subsections (a)(2), (3) and (4).

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.34, 12693.615 and 12693.755, Insurance Code.

2699.6803. Annual Health, Dental and Vision Benefit Plan Rates.

Health, dental and vision benefit plan rates shall be established for each rating period and the rating period for the program shall be a twelve (12) month period.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Section 12693.21, Insurance Code.

2699.6804. Rural Demonstration Project(s) Payments.

In addition to plan rates, the Board may:

(a) Pay plan rate enhancement(s) to a health, dental or vision benefits plan based on the plan's participation in a rural demonstration project(s). Such rate enhancements shall be for the same period as the annual health, dental and vision benefit plan rates.

(b) Provide a grant(s) to a health, dental or vision plan based on the plan's participation in a rural demonstration project(s).

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Section 12693.91, Insurance Code.

2699.6805. Designation of Community Provider Plan

(a) For each benefit year, the Board will designate as the community provider plan in each county the participating health plan with a service area which includes zip codes in which at least eighty-five percent (85%) of the residents of the county reside that has the highest percentage of traditional and safety net providers pursuant to the calculation in (e) below.

(b) By the end of November of each year, the Board shall compile and make available a list for each county of all Child Health and Disability Prevention Program (CHDP), clinic and hospital traditional and safety net providers.

(c) The lists shall be compiled as follows:

(1) The CHDP list shall include all CHDP providers, except for clinical laboratories, that were on the Department of Health Services (DHS) CHDP Master File as of October 1st of that year and which provided a State-Only Funded CHDP service as identified on the CHDP Paid Claims

Tape to at least one (1) child in the state fiscal year that ended immediately prior to the most recently ended state fiscal year. For each provider, the list shall indicate the percentage of county children that received State-only funded CHDP services from the identified provider. The number of county children shall be calculated by summing the numbers of children that received State-only funded CHDP services from each listed provider.

(2) The clinic list shall include all community clinics, free clinics, rural health clinics, and county owned and operated clinics, located in the county, which were so identified by the Medi-Cal program as of October 1st of that year and which were identified on the Medi-Cal Paid Claims Tape as having provided service to at least one (1) child aged one (1) through eighteen (18) in the state fiscal year that ended immediately prior to the most recently ended state fiscal year. For each clinic, the list shall indicate a percentage which shall be equal to one (1) divided by the number of listed clinics in the county.

(3) The hospital list shall include:

(A) For a county that has, located in the county, at least one hospital which was as of October 1st of that year a hospital eligible for the inpatient disproportionate share hospital payment program as reported by the Department of Health Services, a University teaching hospital, a Children's Hospital (as defined in Section 10727 of the Welfare and Institutions Code), or a county owned and operated general acute care hospital, the list shall include all hospitals of one of these types whether or not they are located in the county which reported to the Office of Statewide Health Planning and Development (OSHPD) discharging at least one resident of the county who was a Medi-Cal, county indigent and charity care patient aged one (1) through eighteen (18) in the year for which OSHPD most recently released its annual compilation of Discharge Data. For each hospital, the list shall indicate the percentage of the Medi-Cal, county indigent, and charity care discharges from all listed hospitals of county residents aged one (1) through eighteen (18) that were from the identified hospital.

(B) For all other counties, the list shall include all hospitals located in the county and all hospitals which discharged at least one resident of the county who was a Medi-Cal, county indigent or charity care patient aged one (1) through eighteen (18) in the year for which OSHPD most recently released its annual compilation of Discharge Data and which were a hospital eligible for the inpatient disproportionate share hospital payment program as reported by the DHS, a university teaching hospital, a children's hospital (as defined in Section 10727 of the Welfare and Institutions Code), or a county owned and operated general acute care hospital. For each hospital the list shall indicate the percentage of the

Medi-Cal, county indigent, and charity care discharges from all listed hospitals of county residents aged one (1) through eighteen (18) that were from the identified hospital.

(d) By January 15th of each year, each participating health plan shall submit to the Board for each county the following:

(1) A list of the CHDP providers identified by the Board pursuant to (c)(1) that have a contractual relationship with the participating health plan for the provision of services to program subscribers.

(2) A list of the clinics identified by the Board pursuant to (c)(2) that have a contractual relationship with the participating health plan for the provision of services to program subscribers.

(3) A list of the hospitals identified by the Board pursuant to (c)(3) that have a contractual relationship with the participating health plan for the provision of services to program subscribers.

(e) The percentage of traditional and safety net providers in the provider network of each participating health plan will be calculated by summing the CHDP percentage, the clinic percentage, and the hospital percentage.

(1) The CHDP percentage is calculated by summing the percentages assigned to all CHDP providers in the county identified by the plan pursuant to (d)(1), and multiplying that number by 0.35.

(2) The clinic percentage is calculated by summing the percentages assigned to all clinics in the county identified by the plan pursuant to (d)(2), and multiplying that number by 0.45.

(3) The hospital percentage is calculated by summing the percentages assigned to all hospitals in the county identified by the plan pursuant to (d)(3), and multiplying that number by 0.2.

(f) The Board shall announce the designation of the community provider plan for each county by March 31st of each year for the benefit year beginning on the next July 1st. Prior to designation, each plan’s relationships with traditional and safety net providers may be verified by the Board.

(g) The lists of CHDP providers in (c)(1), clinics in (c)(2) and hospitals in (c)(3) shall only be revised under the following circumstances:

(1) Any CHDP provider not included on a county list pursuant to(c)(1) that believes it met the specified criteria to be on that list and was

excluded in error, may within thirty (30) calendar days after the list is released by the Board, notify the Board that it so believes and provide written documentation demonstrating that it met the listed criteria. If the Executive Director of the Board finds that the CHDP provider did meet the specified criteria it shall be added to the county list.

(2) Any clinic not included on a county list pursuant to (c)(2) that believes it met the specified criteria to be on that list and was excluded in error, may within thirty (30) calendar days after the list is released by the Board, notify the Board that it so believes and provide written documentation demonstrating that it met the listed criteria. If the Executive Director of the Board finds that the clinic did meet the specified criteria it shall be added to the county list.

(3) Any hospital not included on a county list pursuant to (c)(3) that believes it met the specified criteria to be on that list and was excluded in error, may within thirty (30) calendar days after the list is released by the Board, notify the Board that it so believes and provide written documentation demonstrating that it met the listed criteria. If the Executive Director of the Board finds that the hospital did meet the specified criteria it shall be added to the county list.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21, 12693.37, Insurance Code.

2699.6807. Change of Risk Category.

When a subscriber changes county of residence as specified in Section 2699.6800, or transfers between health plans pursuant to Section 2699.6619, the family contributions amount shall be recalculated and changed as of the first of the following month, unless the applicant has a family contribution sponsor.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Section 12693.21, Insurance Code.

2699.6809. Determination of Family Contribution for the Program.

(a) Family child contributions for the program shall consist of one of the following:

(1) A flat fee in each county for a family value package:

(A) Seven dollars ($7) per subscriber child with a maximum required contribution of fourteen dollars ($14) per month for

subscriber children with annual household incomes after income deductions of up to and including 150 percent of the federal poverty level.

(B) Through June 30, 2005, nine dollars ($9) per subscriber child with a maximum required contribution of twenty-seven dollars ($27) per month for subscriber children with annual household incomes after income deductions greater than 150 percent and up to and including 250 percent of the federal poverty level; these rates are also applicable for subscribers who entered the program as AIM infants. On and after July 1, 2005, these rates apply only for subscriber children with annual household incomes after income deductions greater than 150 percent and up to and including 200 percent of the federal poverty level.

(C) On and after July 1, 2005, fifteen dollars ($15) per subscriber child with a maximum required contribution of forty-five dollars ($45) per month for subscriber children with annual household incomes after income deductions greater than 200 percent and up to and including 250 percent of the federal poverty level; these rates are also applicable, through the first year of eligibility, for subscribers who entered the program as AIM infants and for those AIM infants whose annual household income after deductions remains above 200 percent of the federal poverty level after each Annual Eligibility Review.

(2) A flat fee in each county for a family value package that includes a community provider plan:

(A) Four dollars ($4) per subscriber child with a maximum required contribution of eight dollars ($8) per month for subscriber children with annual household incomes after income deductions of up to and including 150 percent of the federal poverty level.

(B) Through June 30, 2005, six dollars ($6) per subscriber child with a maximum required contribution of eighteen dollars ($18) per month for subscriber children with annual household incomes after income deductions of greater than 150 percent and up to and including 250 percent of the federal poverty level; these rates are also applicable for subscribers who entered the program as AIM infants. On and after July 1, 2005, these rates apply only for subscriber

children with annual household incomes after income deductions greater than 150 percent and up to and including 200 percent of the federal poverty level.

(C) On and after July 1, 2005, twelve dollars ($12) per subscriber child with a maximum required contribution of thirty-six ($36) per month for subscriber children with annual household incomes after income deductions of greater than 200 percent and up to and including 250 percent of the federal poverty level; these rates are also applicable, through the first year of eligibility, for subscribers who entered the program as AIM infants and for those AIM infants whose annual household income after income deductions remains above 200 percent of the federal poverty level after each Annual Eligibility Review.

(b) Family parent contributions for the program shall consist of one of the following:

(1) A flat fee in each county for a family value package:

(A) Ten dollars ($10) per month per subscriber parent with an annual household income after income deductions of up to and including 150 percent of the federal poverty level.

(B) Twenty dollars ($20) per month per subscriber parent with an annual household income after income deductions greater than 150 percent and up to and including 200 percent of the federal poverty level.

(2) A flat fee in each county for a family value package that includes a community provider plan:

(A) Seven dollars ($7) per month per subscriber parent with an annual household income after income deductions of 150 percent of the federal poverty level.

(B) Seventeen dollars ($17) per subscriber parent with an annual household income after income deductions of greater than 150 percent and up to and including 200 percent of the federal poverty level.

(c) Applicants who pay in advance the amount of three (3) months of family child contributions shall receive the fourth consecutive month of coverage for a subscriber child with no family child contributions required.

(d) Applicants who pay in advance the amount of three (3) months of family parent contributions shall receive the fourth consecutive month of coverage for a subscriber parent with no family parent contributions required if the subscriber child contributions (if applicable) are also paid in advance, at the same time for the same three month period.

(e) Applicants who pay the family child contributions (if applicable) and the family parent contributions (if applicable) by electronic fund transfer or scheduled credit card payment shall receive a twenty-five (25) percent discount off the monthly combined total of the family child contributions and family parent contributions.

(f) If the applicant is applying for children in more than one household, the income of the household with the lowest annual income after income deductions will be used to determine the family contributions.

(g) If an applicant has a family contribution sponsor, family child contributions and/or family parent contributions that are to be paid by the family contribution sponsor for any twelve (12) consecutive months in the program shall be established based on subsections (a) and (b) above.

(h) If an AIM infant is enrolled in a different health plan from his or her siblings until the Open Enrollment period after the AIM infant's first birthday, the family child contribution will be the family child contribution for the siblings, plus the contribution rate for one more child at the same rate, up to the maximum required contribution.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.43, 12693.53 and 12693.755, Insurance Code.

2699.6811. Notification of Family Contributions Changes.

The program shall notify applicants in writing of a change in family child contributions and/or family parent contributions.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Section 12693.21 and 12693.755, Insurance Code.

2699.6813. Family Contribution Payment for the Program.

Family contribution payment procedures for applicants shall be as follows unless the applicant or person for whom application is being made is an American Indian or Alaska Native and submits acceptable documentation as described in Subsection 2699.6600(c)(1)(GG), or unless the applicant has a family contribution sponsor:

(a) Applicants shall submit their initial family contributions pursuant to Subsection 2699.6600(a). The family child contributions and family parent contributions will be applied for one (1) month or four (4) months, as applicable, starting with the first day of the first full month of coverage. If the applicant or person for whom application is being made is an American Indian or Alaska Native, the family contributions shall not be assessed until the first day of the first full month following the end of the second month of enrollment during which the applicant has not provided acceptable documentation as described in Subsection 2699.6600(c)(1)(GG).

(b) Applicants shall submit their subsequent family contributions to the program so that they are received no later than the monthly due date set by the program.

(c) The program shall apply monies paid first to the family child contributions due, then to the family parent contributions due. Remaining monies shall be applied first to the family child contribution up to the level necessary to earn a free month of coverage, then to the family parent contribution up to the level necessary to earn a free month of coverage, except as provided under Subsection 2699.6605(b)(1).

(d) Applicants who want to receive the one month family contribution discount pursuant to Subsection 2699.6809(c) and (d) must submit their family child contributions, if applicable, and/or family parent contributions, if applicable, at the same time and for the same three (3) month period so that they are received no later than the due date set by the program for the first of the three (3) months.

(e) For each month any family contributions are due, the program shall notify the applicant of the amount of the family contributions due to the program, the due date, and the subscribers for whom the family contributions are being paid. This notification shall be made at least fifteen (15) calendar days in advance of the family contributions due date.

(f) The applicant’s obligation to submit the family contributions is not contingent upon receipt of the notice specified in subdivision (d) above. If the applicant does not receive the notice specified in subdivision (d) above, the applicant shall call the program to determine the amount of the family contributions and shall submit a payment of that amount.

(g) Applicants shall make family contributions in one or more of the following ways: personal check, cashiers check, money order, credit card, debit card, electronic fund transfer, or in cash at designated locations. If a family contribution is paid by a personal check that has been returned for

non-sufficient funds, the Program may specify the form of payment that it will accept for the overdue family contribution.

(h) If a subscriber is disenrolled pursuant to Subsection 2699.6611(a), the applicant will be refunded the unused portion of the family contributions, except as provided in Section 2699.6815(e) and Section 2699.6819(c).

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.43 and 12693.755, Insurance Code.

2699.6815. Overdue Payments; Disenrollment.

(a) Applicants whose family child or parent contributions are not paid in full by the due date shall be considered to be overdue.

(b) The program shall notify applicants of the overdue family child and/or parent contributions and the potential for disenrollment from the program within fifteen (15) calendar days following the due date.

(c) No less than thirty (30) calendar days prior to the date of potential disenrollment pursuant to (e) and (f) below, the program shall provide notice to the applicant of the potential disenrollment as specified in Subsection 2699.6611(b).

(d) If the amount of family contributions paid by an applicant is not adequate to cover the combined amount of the family child contributions and family parent contributions, the program will first apply the monies paid toward the family child contributions with any remainder applied toward the family parent contributions.

(e) If family parent contributions are not paid for two (2) consecutive calendar months, the subscriber parents covered by the family contribution shall be disenrolled pursuant to Section 2699.6611. Termination of coverage shall be at the end of the second consecutive month for which the family parent contributions were not paid in full. Any credit remaining from the family parent contributions after a subscriber parent's disenrollment from the program will be applied toward any family child contributions applicable to a subscriber child who is enrolled in the program and to whom the subscriber parent is linked.

(f) If family child contributions are not paid for two (2) consecutive calendar months, all subscriber children covered by the family child contributions shall be disenrolled pursuant to Section 2699.6611. Termination of coverage shall be at the end of the second consecutive month for which the family child contributions were not paid in full.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code.
Reference: Sections 12693.21, 12693.45 and 12693.755, Insurance Code.

2699.6817. Family Contribution Sponsor Registration.

(a) Family contribution sponsors must register with the Board.

(b) To be registered, a family contribution sponsor must:

(1) complete and return a Healthy Families Program Family Contribution Sponsor Registration form (HFP-Sponsor 1(new 7/00)), which is hereby incorporated by this reference, and

(2) receive a sponsor identification number from the Board.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Sections 12693.21, Insurance Code.

2699.6819. Family Contribution Sponsor Payments.

(a) For each applicant being sponsored, the family contribution sponsor shall submit payment for twelve (12) months of family child contributions if the family contribution sponsor is sponsoring a subscriber child, and twelve (12) months of family parent contributions if the family contribution sponsor is sponsoring a subscriber parent. The family contribution sponsor shall also submit the completed and signed Healthy Families Program Family Contribution Sponsorship Payment form (HFP-Sponsor 2 (new 7/00)) which is hereby incorporated by this reference.

(b) The payment for twelve (12) months of family child contributions shall be the family child contributions amount determined pursuant to Subsection 2699.6809(e) multiplied by 12. The payment for twelve (12) months of family parent contributions shall be the family parent contributions amount determined pursuant to Subsection 2699.6809(f) multiplied by 12.

(c) Payment of the amount specified in subsection (b) above shall be considered payment in full for the applicant for the twelve (12) consecutive months in the Program or, as of the parental coverage start date, for any twelve consecutive months in the program. No premium adjustments will be made for any reason during the period.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code.
Reference: Sections 12693.21 and 12693.755, Insurance Code.

2699.6821. Eligibility as a Family Contribution Sponsor.

(a) The following persons or entities are not eligible to be family contribution sponsor:

(1) a person that is a health care, dental care or vision care provider that participates in the Healthy Families Program or an organization composed primarily of or controlled by such persons,

(2) an entity, including governmental, school, non-profit and charitable organizations, that is ,or that operates, an institution or facility that is a health care, dental care or vision care provider that participates in the Healthy Families Program.

(3) a participating plan.

(4) any person or entity acting on behalf of or representing a person or entity identified in (1) through (3) above.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Section 12693.21, Insurance Code.

2699.6823. Family Contribution Sponsor Certification Requirement.

(a) Any person or entity seeking to provide payment as a family contribution sponsor must certify both of the following:

(1) that the person or entity is not ineligible to be family contribution sponsor under Section 2699.6821, and

(2) that the person or entity acknowledges that the board has taken no position as to whether payment of premiums as a family contribution sponsor by any person or entity would be in violation of federal fraud and abuse laws.

(b) The certification shall be made on the Healthy Families Program Family Contribution Registration form (HFP-Sponsor 1 (new 7/00)).

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Section 12693.21, Insurance Code.

2699.6825. Family Contribution Sponsor Disqualification.

The Board may refuse to allow a registered family contribution sponsor to sponsor any additional applicants if the Board determines that the sponsor has

violated or encouraged an applicant to violate program rules. The sponsor will be notified in writing of such a determination. The sponsor may appeal the determination by filing a written request for review by the Executive Director.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Section 12693.21, Insurance Code.

2699.6827. Payment of State Supported Services.

State Supported Services shall be paid for by State dollars only. No Federal dollars provided to the State pursuant to title XXI of the Social Security Act shall be used.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Section 12693.21, Insurance Code and 42 CFR Section 457.475.

ARTICLE 5: CHILD HEALTH AND DISABILITY PREVENTION PROGRAM PAYMENTS

2699.6900. Child Health and Disability Prevention Program Providers.

(a) For purposes of meeting the requirements of Insurance Code Section 12693.41, regarding reimbursement of providers who participate in the Child Health and Disability Prevention (CHDP) Program, providers are defined as:

(1) CHDP health assessment providers, are those individuals and entities described in Title 17, California Code of Regulations, Section 6860 and 6862, who provide well-child health assessment and immunizations.

(2) CHDP initial treatment providers, are those providers that participate in the Medi-Cal and Denti-Cal program and provide initial treatment of a condition that has been identified during the well-child health assessment.

NOTE: Authority Cited: Section 12693.21, Insurance Code.
Reference: Section 12693.41, Insurance Code.

2699.6903. Reimbursable Services.

(a) For purposes of meeting the requirements of Insurance Code Section 12693.41 relating to the Healthy Families Program reimbursements, a “CHDP well-child health assessment” is as defined in Title 17, California Code of Regulations, Section 6800 and shall include those services specified in Title 17, California Code of Regulations, Section 6846.

(b) For purposes of meeting the requirements of Insurance Code Section 12693.41 relating to the Healthy Families Program reimbursement, “initial treatment” means those services provided in the 90 days prior to a person’s effective date of coverage by a Healthy Families Program participating health plan that are necessary for diagnosis and treatment of a condition identified during the “CHDP well-child health assessment”. These services may include, but are not limited to:

(1) Outpatient physician services including referral to outpatient specialty care, laboratory services, x-ray services, prescription drugs and those medical supplies and equipment necessary to administer prescribed medication.

(2) Inpatient hospital care.

(3) Emergency dental services that are medically necessary for the relief of pain and treatment of infection.

NOTE: Authority cited: Section 12693.21, Insurance Code.
Reference: Section 12693.41, Insurance Code.

2699.6905. Reimbursement Rates.

(a) For the purposes of meeting the requirement of Insurance Code Section 12693.41 relating to the Healthy Families Program, wellchild health assessments and immunizations provided to persons who subsequently enroll in the Healthy Families Program pursuant to Article 2, shall be reimbursed at the rates specified in Title 17, California Code of Regulations, Section 6868. CHDP health assessment providers shall submit claims for these services in accordance with Title 17, California Code of Regulations, Section 6866 to the State Department of Health Services (DHS).

(b) For purposes of meeting the requirement of Insurance Code Sections 12693.41 relating to the Healthy Families Program, providers shall be reimbursed for initial treatment provided to persons who subsequently enroll in the Healthy Families Program pursuant to Article 2, at the Medi-Cal rate, as specified in Title 22, California Code of Regulations, Sections 51501 et. seq. A county that reimburses provider at a county-specific rate that is less than the Medi-Cal rate for treatment services for a condition identified in a CHDP health assessment will be reimbursed by the Healthy Families Program at the rate the county reimburses the treatment provider. Providers shall submit claims to the DHS for these services on the Health Insurance Claim Form (HCFA 1500, revised version 12/90), accompanied by a legible copy of any DHS approved version of the Confidential Screening/Billing Report (PM 160).

NOTE Authority cited: Section 12693.21, Insurance Code.
Reference: Section 12693.41, Insurance Code.